

OPS PHYSICIAN REFERRAL FORM

fax to (317) 817.1737 or email to fax@opsindy.com

REFERRING PHYSICIAN INFORMATION

Date: _____ Referred by: _____

To: _____

Address: _____

NPI#: _____

Secure email address: _____

Phone#: _____

Fax#: _____

Has patient previously been seen by OPS? ☐ Yes ☐ No

If yes, by which physician: _____

REASON FOR CONSULTATION

PATIENT INFORMATION

YOU CAN SEND YOUR DEMOGRAPHIC SHEET IF IT COVERS EVERYTHING LISTED.

Patient's Name: _____

DOB: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Patient Phone Number: _____

Work Phone: _____

Cell Phone: _____

Email address: _____

ONLY to be used to communicate with patient regarding appointments

INSURANCE INFORMATION

WE PREFER A COPY OF THE CARD, FRONT AND BACK

Insurance Plan: _____

ID# _____ Effective Date: _____

Is Auth/Pre-Cert Required? ☐ Yes ☐ No If yes, # _____

Secondary Ins: _____

ID# _____

Effective Date: _____

NOTICE OF CONFIDENTIALITY: THIS FORM IS CONFIDENTIAL AND IS INTENDED SOLELY FOR THE PERSON INDICATED ABOVE. IF YOU ARE NOT THE INTENDED PERSON, YOU ARE HEREBY NOTIFIED OF THE CONFIDENTIAL NATURE OF THIS FORM AND THAT YOU ARE NOT ENTITLED TO READ COPY OR OTHERWISE DISSEMINATE ANY OF THE INFORMATION DISCLOSED IN THIS FORM.