**New Patient Referral**

The following information is required to schedule your patient with Wiregrass Neurology. Please return the completed form by fax to **1-877-361-4549**.

**Patient Information:**

Patient Name (First, Middle, Last):

Home Phone: Work Phone:

Mobile Phone: Date of Birth:

Social Security Number:

**Referring Physician:**

Physician Name: Phone #:

NPI #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_

**Diagnosis or Complaint:**

**Insurance Information:**

Primary Insurance: Insurance Ph:

Name of Insured (if other than patient):

Insured DOB: Insured Social Security #:

Insured ID: Group #:

Sponsor SSN:

**IF PATIENT HAS BCBS AL THAT REQUIRES REFERRAL PLEASE COMPLETE AND ATTACH COPY.**

**PLEASE NOTE: We DO NOT ACCEPT OUT OF STATE MEDICAID. We are NOT AN AMBETTER PROVIDER.**

\*\*Pertinent medical records and a copy of the patient’s insurance cards (front & back) must accompany this referral for an appointment.

Appointment Date: Time: