wellward
Regenerative Medicine

Fax Referral Form

Date: ....

Patient Name: ....DOB: ....SSN: ....

Primary Phone:..Secondary Phone: ....

Mailing Address:...

Prior Authorization Information (PA# and allowable amounts): ....

Primary Insurance: ....ID#:..

Policyholder ....DOB:..

Secondary Insurance: ....ID#:..

Policyholder ....DOB:..

Referring Provider: .... NPI Number: ....

Phone number: .... Fax Number: ....

Contact name:..

Mailing Address: ....

Diagnosis and/or reason for referral: ....

Select what department this referral is for:
referral is for:

- ☐ Pain (<1 wk, <3 mo, or >3 mo)
- ☐ Psychiatry (Lexington Only)
- ☐ Medfit/Weight Loss (Lexington Only)

Select what type of appointment this

- ☐ New Patient Referral
- ☐ Consultation / Second Opinion
- ☐ Procedure Only

  Which procedure? _______________
  Has Authorization been obtained? Y / N
- ☐ Other ________________________________

MUST include the following:

1. Patient's demographic sheet
2. Copy of insurance card(s) and prior authorization confirmation
3. Last **3 months** of progress note(s)
4. Diagnostic radiology report(s): ex. MRI, CT, X-ray, etc. for the **last 2 years**

* Please fax all referrals to the Lexington office at 859-276-5400. Please include this completed form with the requested documents for timely processing. We appreciate your referral and will contact the patient directly to schedule their appointment. Thank you!*

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