carolina developmental pediatrics, pa

1001 w. williams st
suite 104
apex, nc 27502

p 919.362.5406
f 919.362.5409

REFERRAL/CONSULTATION FORM

To be completed by Referring Provider

Patient Information

Last Name______________________________ First Name__________________________________ MI_____

Address ____

City ______________ State ______________ ZIP Code ______________________

E-mail address: ______________________________ Home Phone (___)________________________________

Parent Work Phone (___)____________ Parent Cell Phone (___)___________________________

Patient Birth date:_____/_____/_____ Sex: M F (Circle one) Patient Social Security: __________________________

Emergency contact: ________________________________

Home phone: ______________________ Cell phone __________________________

Reason for Referral

Referring Physician or Provider: ______________________________ NPI ________________________

Practice Address: __________________________________ Phone: ______________________________

____ Fax: ______________________________

City _____________________________ State : _______________ ZIP __________________

Please describe briefly the reason for referral: ____

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Insurance Information

Primary Insurance (circle one): **BCBSNC** **Aetna** **Cigna**

Medicaid (Carolina Access Number _______________________________)

Other: _____________________________

Is Referral or Pre-authorization required: **Yes No** (circle one) if Yes, has pre-authorization been obtained **Yes No** (circle one)

Primary Insurance Holder: Name: _____________________________ DOB: _______________

Employer: ____

Insurance ID number :_______________________________ Group number: __________________

Please fax any pertinent records along with this completed form to (919) 362-5409. Thank you for your time and referral.

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