RIVERSIDE PODIATRY P.C.

ROBERT HOPE D.P.M. NPI 1942307970

535 JACK WARNER PKWY SUITE A1 TUSCALOOSA AL 35404

OFFICE: 205.633.3606 FAX: 205.633.3696

****For EMERGENT PROBLEMS, Requesting Physician *MUST* call our office. All other requests are consider non-urgent.**

Patient's Name: _____ D.O.B. _____

Patient's Address: _____

_____

Patient's Phone #: _____ Cell # _____

Reason for Referral: (be specific) _____

OFFICE NOTES / MUST Be Sent With This Referral Sheet. We will not process the referral until we receive office notes.

Referring Doctor: _____ NPI# _____ FAX# _____

Primary Insurance: _____ *****Self Pay must bring $75.00***
Contract# _____ Group# _____
Name on Ins. Card _____ DOB of Cardholder _____
Secondary Insurance: _____
Contract# _____ Group# _____
Name on Ins. Card _____ DOB of Cardholder _____

PRIOR AUTHORIZATIONS(IF NEEDED FROM INSURANCE) MUST BE FAXED WITH THIS REFERRAL SHEET. IF PRIOR AUTHORIZATION IS NEEDED BUT NOT RECEIVED WE WILL NOT PROCESS THE REFERRAL UNTIL WE RECEIVE AUTHORIZATION.

APPT: DATE _____ TIME: _____ PATIENT CONTACTED: _____