SUPERIOR
Ear, Nose & Throat
Allergy & Audiology

*Philip D. Heichel, MD*

# ***REFERRAL FORM***

**Please complete this form and fax to 906-225-7665**

Date of request: ____/____/____ Referring Physician: _____

Referring Phone #:_____ Referring Fax #: _____

Reason for Referral:_____

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**Forms REQUIRED with referral: H&P, medication list, all pertinent office notes, imaging and labs in regards to referred condition and copies of insurance cards. (check items sent below)**

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|---|---|---|
| _____H&P | _____Imaging | _____Hearing Test |
| _____Medication List | _____Labs | _____Biopsies / Pathology |
| _____Office Note(s) | _____Insurance Card(s) | |

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Patient Name:_____ M / F DOB:_____/_____/_____

Patient Address:_____ City:_____ Zip:_____

Phone: (H)_____ (W)_____ (C )_____

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Guarantor Name:_____ DOB:_____/_____/_____

Relationship:_____

Guarantor Name:_____ DOB:_____/_____/_____

Relationship:_____

Guarantor Address:_____ City:_____ Zip:_____

Phone: (H)_____ (W)_____ (C )_____

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**Insurance information (include a copy of BOTH sides of insurance card(s) if possible)**

Company:_____ Member ID:_____ Group #:_____

Policy Holder:_____ DOB:_____ Relation to Patient:_____

Claims Mailing Address:_____

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Company:_____ Member ID:_____ Group #:_____

Policy Holder:_____ DOB:_____ Relation to Patient:_____

Claims Mailing Address:_____

Please notify patient that they may call our office to schedule after 48 hours to allow us time to input referral information. If you feel that the referral is urgent, please **PAGE** provider via **UPHS M** to discuss and expedite the scheduling process.