Active Physical Medicine & Pain Center, PLLC
6007 US Route 60 East, Ste 304 Barboursville, WV 25504
Phone(304) 736-0825 Fax(304) 736-3199

REFERRAL FORM

Today's Date:_____

Patients Name:_____ **Date of Birth:**_____/_____/_____

Address:_____ **Soc. Sec. No.:**_____-_____-_____

City:_____ **ST:**_____ **Zip:**_____

Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____

Work Phone:(_____)_____-_____ **Alt Phone:** (_____)_____-_____

Diagnosis:_____

Reason For Referral:
- ☐ **Evaluation & Management**
- ☐ **Recommendations ONLY**
- ☐ **Injection/Type:**_____
- ☐ **EMG/NCV (Electrodiagnostic Study)**
  - **Upper Extremity RT**_____**LT**_____
  - **Lower Extremity RT**_____**LT**_____

Insurance Company:_____ **Phone:Number:**(_____)_____-_____

Id#:_____ **Group#:**_____

Guarantor's Name:_____ **Date of Birth:**_____/_____/_____

Guarantor's SSN:_____ **Employer:**_____

Is Pre-Cert Required? _____**yes** _____**no** **If yes, please do so.**

Attorney Case: YES ◯ **NO** ◯ **If yes, Attorney's Name:**_____

Is this condition due to a work related injury? YES ◯ **NO** ◯

Referring Physician:_____ **Office Contact:**_____

Address:_____ **Phone:**(_____) _____-_____

_____ **Fax:** (_____) _____-_____

UPIN:_____ **NPI:**_____

PLEASE NOTE:
- ■ **Please call prior to sending referral. Form must be filled out completely.**
- ■ **Please send all medical records/insurance cards with referral.**
- ■ **We confirm all appts 24hrs in advance- please provide us with a working number.**
- ■ **We accept all insurances EXCEPT Medicaid, or Worker's Compensation.**

Thank you for your referral !!