Integrative
Arthritis + Pain Consultants

2719 Graves Drive, Suite 14 | Goldsboro, NC 27534 | O: 984-207-9440 | F: 919-344-0257

Referral Form

****Is this appointment related to auto accident or workers compensation? _____****

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

_____

SSN: _____

Primary Phone: _____ Alternate Phone: _____

Insurance: _____ **Policy Number:**_____ **Group #**_____

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Tricare: *Sponsor* Name/DOB: _____ ID Number: _____

VA or Veterans choice authorizations must be obtained prior to scheduling appointments.

Medicaid: Yes/ No CA # _____ Number of visits authorized_____

Please send photo copy of insurance card along with this referral

Referring Physician: _____ NPI #_____

Facility Name: _____

Facility Address: _____

Phone: _____ *Fax: _____

Reason for Referral: _____

Specialty/Physician patient is being referred to: _____

Contact person for appointment information: _____ Phone: _____

Note: Please fax demographics, insurance cards, office notes, labs, and studies relevant to the appointment along with the referral form to (919)344-0257. Our office will contact the referring physician's office with an appointment date and time. IF THE PATIENT NEEDS AN AUTHORIZATION FOR AN OFFICE VISIT, ****PLEASE OBTAIN THE AUTHORIZATION PRIOR TO SCHEDULING AN APPOINTMENT. Failure to do so may result in delayed scheduling.

Our office will notify your patient of their appointment through letter. If you have any questions regarding our referral process please call our office.

Referrals without records and insurance cards will not be scheduled.