Internal Medicine Medical Specialties @ Shands Hospital Phone: (352) 265-0139

REFERRAL INFORMATION FORM Fax: (352) 265-7091

PLEASE PRINT ALL INFORMATION – IF PATIENT HAS HMO INSURANCE, MUST HAVE AUTH BEFORE APPT SCHEDULED

GI Fax Date:____/_____/______ **Referring MD Fax Date:_____/______/_______**

__________________ (First Name) __________________ (Middle Name) __________________ (Last Name)

SSN:_______/________/_______ **Male/Female** **Date of Birth______/______/___________** mm dd yyyy

Married/Single (circle one) **Race: Black/White/Other__________________(circle one)**

Mailing Address___________________________ City:_____________________ State:_____ Zip:________________

Phone #: (______)_________-______________ **Alternate Phone #: (_____)_________-_______________**

__________________ (First Name – Next of Kin) __________________ (Last Name – Next of Kin) __________________ (Relationship to Patient)

Diagnosis: ____

ICD-9 Diagnosis Code: ___________________ **Fax this completed form along with medical records to 352-265-0673**

Request for what kind of services (circle one): Consultation, Treatment, Other – explain:___________________

Referring MD Name:___________________________ **Are you PCP (circle one) Yes/ No**

Referring Phone #:_______________________ **Referring Fax #:_______________________**

Mailing Address:_______________________ City:____________________ State:_____ Zip:________________

UPIN #:______________________ Medicare Number:___________________ Specialty:___________________

Insurance Co:___________________________ **Policy #:___________________________**

Policy Holder's Name:___________________________ **Holder's SSN:__________/____________/______________**

Insurance Co. Phone #:(_______)_____________-_________________ **Authorization #:_______________________**

Auth Expiration Date:_______________________

# of visits:_______________________

Secondary Ins. Co:___________________________ **Policy #:___________________________**

Policy Holder's Name:___________________________ **Holder's SSN:__________/____________/______________**

Insurance Co. Phone #:(_______)_____________-_________________ **Authorization #:_______________________**

Auth Expiration Date:_______________________

# of visits:_______________________

***Does authorization(s) include labs (circle one) Yes/ No**

Please Note: If patient does not have insurance, doctor visit can cost between $90 - $517 due the day of the visit.

Office Use Only