5670 Peachtree Dunwoody Road
Suite 1200
Atlanta, GA 30342

Referral Request Form

Primary Care Physicians of Atlanta, P.C.

Phone: 404-255-9100
Fax: 404-257-7171
www.pcpatl.com

PLEASE COMPLETE THIS SECTION:

Patient's Name:_____ DOB (M/D/Y):_____/_____/_____ Gender: ☐ M ☐ F

Preferred Phone #:_____ Alternative Phone #_____

Patient's Insurance Company Name:_____

(if NOT Medicare) Please check one: ☐ HMO ☐ POS ☐ PPO ☐ Other/Not Sure

Insurance ID#_____ Group#_____

Primary Care Physician's Name:_____

Specialist/Facility Name (or check this box if you need a recommendation ☐ _____

Specialty:_____

Reason for Referral (briefly): _____

Additional Information you think we may need to process your referral: _____

_____

FOR OFFICE USE ONLY

ICD 9 Code/CPT code: _____

☐Specialist ☐ Facility ☐Urgent Care Facility ☐ Physical Therapy ☐Chiropractic Services:

Name: _____

Phone #: _____ Fax #: _____

Address: _____

_____

Referral #: _____ # of Visits: _____ Expiration Date: _____

Comments: _____

_____

_____ _____ Faxed to: ☐ Specialist ☐ Insurance Co. ☐Patient

Signature Date completed