____ OK to schedule_____ Insurance/Copay notes

APPOINTMENT _____

Called _____

Called _____

*Called*_____

PAR REHAB SERVICES REFERRAL FORM

Phone: 517-887-9801 Fax: 517-887-9826

☐ Hospital Follow-Up (Internal Only) ☐ M ☐ A ☐ E (Counseling Only)

Date: 1/7/19 ☐ Neuropsychological Eval (PhD) ☐ Psychological Eval (PhD)

☐ Counseling ☐ Substance Abuse ☐ Psychiatry/Medications (MD/DO)

Patient Name: _____ **DOB** _____

First Last

Address: _____

Primary phone: _____ **Work phone:** _____ **Other:** _____

☐ **Male** ☐ **Female** **SSN:** XXX-XX- _____ **Previous Patient:** _____

When

☐ **Parent** ☐ **Guardian** ☐ **Spouse** **Name:** _____

First Last

Presenting Concerns: _____ **Legal in nature** : ☐Y ☐ N

Other Pending PAR Referrals **(Internal Use** ☐ NP/PE ☐ MH ☐ Med. Mgmt.

Name of Caller: _____ **Phone Number:** _____

Referral Source: _____ **Fax Number:** _____

Complete Address: _____

Primary Care Physician: _____ **Phone Number:** _____

Complete Address: _____ **Fax Number:** _____

********** **PAR STAFF ONLY** **********

Diagnosis Codes: ICD-10 (NP) _____ ICD-10—Axis I: _____

#		DATE	#		DATE	#		DATE	
1	**90791**	_____	**1**	**96132** (np)	_____	**1**	**96130** (pe)	_____	**Tech:** _____
1	**96138**	_____	___	**96133** (np)	_____	___	**96131** (pe)	_____	**PhD:** _____
___	**96139**	_____							

Referral Form – Page 2 **Patient Name:** _____ **DOB:** _____

Insurance Verification Notes and Billing Instructions

Primary Insurance _____ **Phone #** _____

Cont # _____ **Group #** _____

Subscriber _____ **DOB** _____ **Employer** _____

Date Verified _____ **Contact Person** _____

Call Notes: _____

_____

_____

Secondary Insurance _____ **Phone #** _____

Cont # _____ **Group #** _____

Subscriber _____ **DOB** _____ **Employer** _____

Date Verified _____ **Contact Person** _____

Call Notes: _____

_____

_____

Auto/WC Insurance _____ **Phone #** _____

Address _____

DOI _____ **Claim #** _____ **Open Y/N** **COB Y/N** **Contacted Adj. Y/N**

Date Verified _____ **Adjuster** _____

Call Notes: _____

_____

_____

***** <u>Including a copy of the patient's insurance card(s) does not replace this page. Please fill in as much information as possible, including a phone number for us to contact the insurance company. Thank you!</u> *****