

# VITALÉ

DERM & AESTHETICS

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## REFERRAL FORM

Date of Referral \_\_\_\_\_

### Patient Demographics

Patient Name (Last, First, MI): \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Other Number: \_\_\_\_\_

### Insurance Information (circle where appropriate)

Guarantor: SELF or \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Plan: COMMERCIAL MEDICARE MEDICAID SELF-PAY

Carrier Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

### Referring Provider Information

Provider's Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Office Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

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### Appointment Details

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

\_\_\_\_\_ Unable to contact patient after two attempts to schedule an appointment, please have patient contact office to proceed with requested referral.

○ Attempt 1 Date/Time: \_\_\_\_\_

○ Attempt 2 Date/Time: \_\_\_\_\_

**PLEASE FAX REFERRAL REQUEST AND PERTINENT INFORMATION (INSURANCE CARD, VISIT NOTE, ETC.) TO 859-740-3378**