Pinehurst Rheumatology

4204 Murdocksville Road, West End, NC | 1413 Greenway Court, Sanford, NC
Phone: 910-255-0055 | **Fax:** 910-255-0060
www.pinehurstmedical.com

To ensure that this request is processed as quickly as possible, please follow the instructions outlined below:

1. **Complete all fields** of the form & **fax all related documents** office notes, labs, imaging results.
   Please fax copies of any insurance cards
2. **Fax the completed form and required documents to: 910-255-0060**

PATIENT INFORMATION

Last Name ______ First Name ______ Middle Initial ______ Date of Birth (Month / Day / Year) ______

Address ______ Social Security Number ______

City ______ State ______ Zip ______ Phone Number ______

Date of referral ______ Sex ❑ Male ❑ Female

INSURANCE INFORMATION **fax copies of front and back of card(s)**

Carrier ______ Name of Participant and Date of Birth (if different than patient) ______

Policy Number ______ Participant Number ______ Issue Date ______

REFERRING PROVIDER INFORMATION

Referring Provider Name ______ Title ______ Phone Number ______

Address ______ Fax Number ______

City ______ State ______ Zip ______ PCP or Specialty-Specify ______

REASON FOR REFERRAL

Diagnosis: ______

ICD-10 Code: ______

TO BE COMPLETED BY RHEUMATOLOGY OFFICES ONLY

Appointment Date ______ Time ______

MD Name ______

PLEASE NOTE: Once we have received your referral, we will review the information and contact your patient to set a new patient appointment.

- After arranging the appointment, we will fax back the appointment date and time to your office.
- We will send an informational packet to the patient reminding them of their appointment date and time, directions to the office and new patient forms.

7/2018

**Please visit the PMC Website for an up to date list of insurance carriers prior to referring.*
www.pinehurstmedical.com/pinehurst-medical/contracted-payer-list