Out-of-Network Referral Request Form

Phone: 800.553.6027
Please complete form and fax to:
812.378.7054 or
317.860.3601

Patient Name:____

Date of Birth: ______/______/________ Patient ID Number:______________________________

Diagnosis (Include ICD9 Codes):______________________________________

____

Date of Service:______/______/________

Requesting Physician Name:______________________________________

NPI/TIN:__________________________ Contact Name:__________________________

Phone:______________________________ FAX:______________________________

Address____

Vendor/Facility Name/Referred-to Provider Name:______________________________

NPI/TIN:__________________________

Phone:______________________________FAX:______________________________

Address:____

Date of Appointment (if known):______/______/________Date of Surgery (if known)::______/______/________

Requested Number of Visits:____________ Requested Date Range:__________________________

PLEASE FAX APPROVAL/DENIAL TO: 812.450.8131

Comments:____

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