REFERRAL FORM

Ph: (469) 589-1871
Fax: (469) 589-1872
rennerpainandspine.com

RENNER PAIN & SPINE

DATE OF REFERRAL:

Requesting Provider: NPI:

Phone: Fax:

Primary Care Provider (*if different):*

Primary Care Provider Fax:

PATIENT INFORMATION:

First Name: Middle: Last Name:

Date of Birth: Patient Phone Number:

Type of pain: Spine: [ ] Neck [ ] Mid Back [ ] Lower Back
[ ] Knee [ ] Shoulder [ ] Compression Fracture
[ ] Cancer Pain [ ] Neuropathy

Special Instructions / Procedure Request:

Attached Documentation: [ ] Imaging (MRI, X-Ray, CT) [ ] Tests (EMG, labs)
[ ] Office Notes [ ] Other:

INSURANCE INFORMATION:

Type: [ ] Commercial [ ] Medicare [ ] Medicaid [ ] Workman's Comp
[ ] LOP / MVA [ ] Self Pay [ ] Other

[ ] HMO: [ ] HMO Referral Submitted. Provider NPI: *1972946077* Practice NPI: *1821611153*

Primary Insurance: Secondary Insurance:

ID / Claim #: ID / Claim #:

Adjustor/Attorney: Adjustor/Attorney Phone:

FAX FORM TO 469-589-1872
PLEASE INCLUDE APPROPRIATE IMAGING REPORTS AND OFFICE NOTES