REFERRAL FORM

DATE OF REFERRAL:

PATIENT INFORMATION:

Name (Last, First, MI):	Sex: Male / Female
DOB (MM/DD/YYYY):	Cell Phone:
Address:	

PRIMARY INSURANCE INFORMATION:
(Attach Copy of Front & Back of Insurance Card)

Insurance Carrier:	Subscriber Name:
Subscriber Number:	Subscriber DOB:
Group Number: (If applicable)	HMO/PPO: (If applicable)

PRIMARY OR REQUESTING PROVIDER:

Name & Degree:	NPI:
Phone Number:	Fax Number:

CONSULTING PROVIDER:

GROUP NAME: **Arizona Infectious Disease PLLC**	NPI: **1265904338** Tax ID: **83-2602750**
PHONE NUMBER: **623-244-0050**	FAX NUMBER: **623-244-0100**
ADDRESS: **5601 W Eugie Ave, Ste 204, Glendale, AZ 85304**	

REFERRAL INFORMATION: (REQUIRED)

Reason for Referral (Including ICD 10 code):
Name & Signature of Person Completing This Form:
Authorizing Provider Signature:

Please send relevant office notes, culture report and blood work.