

# PEACE OF MIND, INC.

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## REFERRAL FORM

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Parent or Legal Guardian's Name: \_\_\_\_\_

E-mail address : \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Policy # or ID: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ SS# \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Policy Holder's Phone #: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Physician's Name /Signature: \_\_\_\_\_

MD Telephone/Fax Number/E-mail: \_\_\_\_\_

Carolina Access Primary Care/NPI Provider Number: \_\_\_\_\_

Presenting Problem/Reason for Referral: \_\_\_\_\_

Please fax completed referral forms along with HIPAA compliant cover page to:

**(910) 814-2167**

*OFFICE USE ONLY:*

Insurance Authorization: \_\_\_\_\_