Referral Form

*Please fax this referral to **(513) 986-5069** or email to **referrals@PPTIpain.com**. We will contact your patient to schedule an appointment. Your office will receive notification of the appointment date.*

Referral Date: ______________________

Patient Name: ______________________

Patient DOB: ______________________

Address: ______________________

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Phone: ______________________

Alternate Phone: ______________________

Primary Care Provider: ______________________

Primary Insurance: ______________________

Primary Insurance ID: ______________________

Secondary Insurance: ______________________

Secondary Insurance ID: ______________________

Referring Provider: ______________________

Referring Phone: ______________________

Referring Fax: ______________________

Location Requested: ☐ Loveland ☐ Mt. Orab ☐ Hillsboro

Reason for Referral (Primary Pain Issue): ______________________

Type of Service Requested (Check One):

☐ Evaluate & Treat ☐ Procedure (List Type): ______________________

☐ Urgent Appointment Request (List Reason): ______________________

If prior authorization/pre-certification is required, list authorization number: ______________________

Please submit the following information with the referral (if available):

- Demographics sheet
- Copy of insurance card or BWC information
- Recent office notes and procedure notes
- Most recent medication list
- All available imaging reports

Office Use Only:

Appointment Time: ______________________

☐ Patient Contacted ☐ Referring Provider Contacted ☐ Insurance Verified