Referral Form

Premier
Pain Treatment Institute

*Please fax this referral to **(513) 986-5069** or email to **referrals@premierpaintreatment.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: _____

_____

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**
1301 Mattec Dr.
Loveland, OH 45140

☐ **Mt. Orab**
111 Vandament Way
Mt. Orab, OH 45154

☐ **Hillsboro**
11121 Northview Dr., Ste 2
Hillsboro, OH 45133

☐ **Middletown**
4701 Central Ave.
Middletown, OH 45044

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