REFERRAL REQUEST FORM

Please complete all required fields. Incomplete forms may delay your referral or cause it to be denied by your insurance.

AGREEMENT

This form may only be completed for current patients in good standing with Union Mill Pediatrics, PC.

I understand that a referral or authorization does not guarantee that my insurance company will cover office visits to a specialist. It is my responsibility to know my insurance and what it will cover for medical costs. I understand that Union Mill Pediatrics, PC is in no way responsible for any billing issues that may arise from visits to a specialist.

Referral requests for appointments in less than 5 full business days are subject to a $10 fee. Same day, non-urgent referral requests will be subject to a $25 fee. This excludes emergency issues or referrals ordered as stat by the doctor). Fees will be billed to the responsible party on file and must be paid within 30 days.

I understand that my child should be seen yearly for well checks and must have been seen within the last twelve months for the issues requiring this referral (unless it is on-going, chronic in nature, or an emergency). If Union Mill has not seen my child for this issue, a referral cannot be completed. I further understand that I am responsible to know the number of visits available or the expiration date of a referral.

Union Mill pediatrics cannot back-date referrals.

SIGNATURE: ____

DATE: ____

Completion of this page is required and designates your understanding and agreement.

Complete form and send to:
Referrals@unionmillpediatrics.com
Or FAX 703-802-6307
Or drop at office, 8-5, Monday-Friday; a minimum of 5 business days before appointment

Date: ___________________

Patients Name:_________________________________DOB:___________________

Parent Name:________________________________Phone:____________________

Insurance Carrier Name: ____
Must match information on registration form in chart. An updated form is required for each child yearly or when there are changes to information.

Insurance ID# & Group #____

Policy Holders' SSN#____

Condition requiring referral:____
PLEASE NOTE: Patient MUST have been seen in our office within last 12 months **for this issue** if referral is to be completed

Specialist Name:________________________________Appt. Date:___________

Name of Practice: ____

Address:____

____

Phone:_________________________ Fax:___________________________________
REMINDER: Referral requests for appointments in less than 5 business days subject to a $10 fee, same day $25 fee. (Excludes emergency referrals or those ordered stat by our doctor.) A delay may result if all necessary information is not provided.

FOR OFFICE USE:

Diagnosis: ________________________ Code:____________________________

Provider #____
ME WE SK PD

Authorization # ____

Expires/# of Appts____
Notes:____

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