Physician Communication

Patient name	Member ID number

Referring provider information

Provider	
Phone number	Fax number

Reason for visit (Include pertinent history, physical examination information, lab results, X-ray studies, etc. Attach any available reports).

MD/DO signature

Specialist Information

CPT-4/ICD-10

Working diagnosis

CPT-4/ICD-10

Recommendations – Suggested timeframe and purpose for return visit, if requested. Attach any applicable reports.

MD/DO signature	Date	Phone number