Date:

NC NEUROPSYCHIATRY

NEW PATIENT REFERRAL REQUEST – Fax all requests to: (984)235-1617

PLEASE NOTE: INCOMPLETE REFERRALS will be faxed back requesting the missing information. Thank you!

Referred By _____ **NPI#:** _____

Practice Name _____ **(NPI IS REQUIRED FOR ALL MEDICAID REFERRALS)**

Address_____

Phone#: _____ Fax#: _____

Patient Name _____ Date of Birth _____

Complete Address _____

_____

Phone#: _____

Email: _____

Please check:
☐Male ☐Female

If Applicable: Parent/Guardian/Guarantor _____

Relationship to Patient _____

Address _____

Phone# _____

**** Please provide us with the information below OR provide a copy of the front and back of ALL insurance cards. ****

Primary Insurance

_____

Policy #/Member ID

_____

Group # _____

Insured's Name and Date of Birth

_____

Payer ID

_____

Secondary Insurance

_____

Policy #/Member ID

_____

Group # _____

Insured's Name and Date of Birth

_____

Payer ID

_____

Referral Requested To: (Select ONE or specify BOTH needed)

☐ Neuropsychological Testing **(Aaron Hervey, PhD-Evaluation ONLY)** (Please provide referral question/diagnosis codes & records)

☐ Neuropsychiatric Evaluation **(C. Tom Gualtieri, MD—Evaluation and Med. Management)**

Reason for Referral

_____

_____

_____

_____

_____