diagnostichealth 1025 Berkshire Blvd. Suite 500 • Wyomissing, PA.19610 • Phone: 610-478-8797

Fax Referral Sheet

(Not a script)

Fax to: 610-478-8859

(Please print legibly)

Practice Name: ______________________________

Phone: __________ Fax: __________ Date: __________

Patient Name: ______________________ DOB: __________

Physicians Name: ______________________ Phone: __________

Study Requested: (send script separately) ______________________

INSURANCE:

Name: ______________________________

ID#: ______________ Authorization: ______________

WC/AUTO:

Company: ______________________________

Address: ______________________________

Claim#: ______________ DOI: ______________

Insurance Adjuster: ______________________ Phone: __________

Authorization for Treatment? Y N Claim Exhausted? Y N Claim Cap Amount: __________

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