A division of BASS MEDICAL GROUP

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REFERRAL FORM

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Insurance (primary): _____ ID: _____

Insurance (secondary): _____ ID: _____

We are in-network with Medicare, most PPO insurances, and some HMOs (no Covered California nor EPO plans). We are not contracted with Medi-Cal. HMOs require an authorization to be in place in order to be seen.

Reason for Request:

_____

_____

_____

_____

_____

_____

_____

Requesting physician: _____ Phone: _____

NPI #: _____ FAX: _____

Specialty: ☐ Cardiology ☐ Pulmonary ☐ Neurology ☐ ENT

☐ Family Practice ☐ Internal Medicine ☐ Other: _____

Signature: _____ Date: _____

Please attach patient's history and physical, list of medications, and copy of insurance card.

Fax to (408) 770-4727

Thank you in advance for your request.