PLEASE COMPLETE ALL FIELDS AND FAX TO:

305-675-3244

PCP Specialty Referral Form

Date of Request:_____		
Referral Begin Date:	**Referral End Date:**	**Number of visits: 2**
Member Name:	**D.O.B.:**	**Member ID:**
Diagnosis:		
Reason for Referral:		
Referring Provider:	**NPI:**	**Specialty:**
Phone:	**Fax:**	**Email:**
Servicing Provider:	**NPI:**	**Specialty:**
Phone:	**Fax:**	**Email:**
Disclaimer: This referral is valid for 90 days from date of issue for a maximum of 2 visits and includes visits and in-office procedures that are medically necessary and within the providers' scope of pratice.		

PLEASE COMPLETE ALL FIELDS ABOVE AND FAX TO: 305-675-3244