



BAY REGION

Bay Neurology – REFERRAL FORM

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Bay Neurology
4175 N. Euclid Ave.
Suite 12
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Referring Office: Please complete entire form and **FAX to 989-667-3411**. Thank you!

Today's Date: _____ Patient Name: _____

Gender: Male Female Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email address: _____

Referring Physician: _____ Phone: _____ Fax: _____

Reason for Referral: _____

Family Physician: _____ Phone: _____ Fax: _____

PRIMARY INSURANCE: _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

Patient ID #: _____ Group#: _____ Effective Date: _____

SECONDARY INSURANCE: _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

Patient ID #: _____ Group#: _____ Effective Date: _____

1. Does patient's insurance require a referral and/or authorization? Yes No

If YES, please send a copy of the authorized referral.

2. Referring office to check tests completed and FAX results:

EMG/NCS MRI MRA CT EEG LABS Other: _____

Please FAX this form back to us with labs, tests, notes, **including other physician's notes, records, and any information pertaining to this referral**. Please include all insurance information and prior authorization that may be required. We will review all information prior to contacting the patient with a scheduled appointment.

BAY NEUROLOGY USE ONLY

Appointment: Date: _____ Time: _____

Patient Notification: Date: _____ Initials: _____

Referring Provider Notified: Date: _____ Initials: _____

New Packet Mailed On: Date: _____ Initials: _____

Insurance Verified: Yes No Method: _____