ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.

904.209.1051 (direct referral line) 904.209.1032 (direct referral fax)
Secure Online Form available on our website @ www.oastaug.com

Referring Physician Form

REFERRING PHYSICIAN: Date:_____

Name of Referring Physician:_____

Contact Name:_____ Phone#:_____ ext._____

PATIENT INFO:

Last Name:_____ First Name:_____ Gender:_____

Address:_____

City:_____ State_____ Zip:_____

Date of Birth:_____ SSN:_____

Home Phone:_____ Work Phone:_____

INSURANCE CARRIER INFO:

Authorization # (ie. Humana)_____

Name of Insurance: (No BCBS HMO):_____

Subscriber Name:_____ Subscriber DOB: _____

Subscriber ID:_____ Group #:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Relation to Subscriber:_____

REFERRAL INFORMATION:

Physician Requested:_____

Reason for Referral/Diagnosis (ICD-9)

Check Box if Patient had: ☐ MRI ☐ X-Rays ☐ EMG ☐ CT Scan

Performed by: ☐ Flagler Hospital ☐ St. Augustine Imaging ☐ Other:_____