REFERRAL FORM

CLARUS
HEALTH ALLIANCE
40 Connecticut Ave
Norwich, CT 06360
t: 860.889.7274
f: 860.889.2131

REASON FOR REFERRAL

Problem(s)_____
*Please fax office notes: Problem list, medications, labs/neuroimaging results, etc.

Duration of problems_____

Goal of exam_____

PATIENT INFORMATION

Patient's Name_____DOB_____Gender: M____F____

Address_____City_____State_____Zip_____

Patient's Phone# Home_____Cell_____

Contact Person (if not patient) _____Relationship_____

Phone#_____

INSURANCE INFORMATION

Insurance Carrier_____ID#_____ Group#_____

Subscriber name _____(If not the patient)

Relationship to patient_____ Subscribers DOB_____
**Front & Back of insurance card required when carrier is not Medicare or Medicaid
***If insurance card not available, provide phone number where providers can get pre-authorization and benefits.

PROVIDER INFORMATION

Referring Provider_____

Specialty/Discipline_____Organization_____

Address_____City_____ State____ Zip_____

Phone #_____Fax#_____NPI#_____

FAX COMPLETED FORM: 860-889-2131 Questions? Call 860-889-7274