



4904 Fayetteville Road, Suite A  
Lumberton, NC 28358

**Referring Practice Information**

Date of Referral:

Referring Practice:

Referring Provider:

Practice Fax #:

Practice Phone #:

Referral Coordinator Name:

**Patient Information**

Patient Name:

DOB:

Gender:

Phone Number:

Address:

For Pediatric patients please include the parent/legal guardian's name:

Parent/Legal Guardian Name:

**Reason for Referral:**



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Lumberton, NC 28358

**Insurance Information**

**Primary Insurance**

**Type:**    Commercial    Medicaid    Medicare    TriCare    State/Federal    Self-pay

**Insurance Company:**

**Member/Subscriber ID #:**

**Group #:**

If the patient is **not** the policy holder please enter the **POLICY HOLDERS** name and DOB

Subscriber Name:

Subscriber DOB:

**Secondary Insurance**

**Type:**    Commercial    Medicaid    Medicare    TriCare    State/Federal    Self-pay

**Insurance Company:**

**Member/Subscriber ID #:**

**Group #:**

If the patient is **not** the policy holder please enter the **POLICY HOLDERS** name and DOB

**Subscriber Name:**

**Subscriber DOB:**

I certify that my practice has obtained any required authorization for this referral and transmission of records.