REQUEST FOR CONSULT

DATE OF REQUEST: _____ **CONTACT PERSON FAXING REQUEST:**_____

NEUROLOGY (ATT: Robin Kyzer)
FAX: 803-545-6063

PLEASE FAX BACK TO US THE FOLLOWING:

Copies of front and back of insurance cards.

Insurance referral/AUTHORIZATION #, if necessary – IMPORTANT

All information MUST be received prior to scheduling the appointment. Each request will be reviewed and assigned to the appropriate physician according to their diagnosis. You will then receive a faxed confirmation of the appointment.

REFERRING PHYSICIAN: _____

UPIN#:_____ **TAX ID #:**_____**OFFICE #:**_____ **FAX #:**_____

REASON FOR REFERRAL: - _____

PATIENT NAME: _____ **DOB:**_____

PHONE #'s: _____**(H)**_____**(W)**_____**(C)**

ADDRESS: _____
SS# _____-

PRIMARY INSURANCE: _____ **ASSIGNED AUTHORIZATION #:**_____

IS THIS WORKERS COMPENSATION OR MVA RELATED:_____

GUARANTOR: _____**POLICY #:** _____ **GROUP #:** _____

Questions regarding Neurology services , should be directed to Robin Kyzer at 803-545-6050.

Thank you for referring your patient to the University Specialty Clinic, Division of Neurology, Department of Neuropsychiatry and Behavioral Science.

8 Richland Medical Park, Suite 420 Columbia, SC 29203 (803) 545-6050