

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.

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