Referral Form

Port City Neurosurgery & Spine
George A. Alsina, MD
Adam P. Brown, MD
Thomas E. Melin, MD

REFERRING PHYSICIAN: _____
Full Name NPI #

_____
Phone # Fax # Direct Mail Address (EMR)

Reason for Referral: _____

When does patient need appointment? (please choose) ◉**First Available** ○**ASAP**

PATIENT: _____
First Name Middle/Maiden Name Last Name Suffix

_____
Street Address / P.O. Box City State Zip

_____
Date of Birth Age Sex Marital Status Social Security #

_____
Home Phone # Work Phone # Cell Phone # Email Address

PRIMARY INSURANCE: _____
Insurance Company Name Policy Holder Name and Date of Birth

_____
Policy ID # Group # Date of Injury

We are OUT OF NETWORK with United Healthcare, Cigna, and Aetna and MUST have a clinical GAP or "network adequacy" authorization before we can schedule a patient. This authorization must originate from an in-network doctor. Please contact the authorization department for the patient's insurance to request this. Authorizations should be requested under the practice's name whenever possible.

Our Tax ID is 26-3847109. Please request the GAP for ALL of the following CPT codes for **3 visits each** over a **3 month period**: **99243, 99244, 99245, 99212, 99213, 99214, and 99215**.

Please call us if you have questions at ext. 110.

_____ _____
GAP/Authorization # **Contact name and # at your office**

SECONDARY INSURANCE: _____
Insurance Company Name Policy Holder Name and Date of Birth

_____
Policy ID # Group #

Required for Patient Scheduling: Insurance card copy, Office Notes, Op Notes, Radiology Reports
*****PATIENT MUST BRING ALL FILMS TO THE APPOINTMENT*****

PLEASE NOTE: WE CANNOT SCHEDULE PATIENT UNTIL WE RECEIVE ALL INFORMATION. INSURANCE INFORMATION MUST BE CURRENT.

Telephone contact after faxing referral is recommended for ASAP or urgent patients.

2800 Ashton Dr. Ste 200
Wilmington, NC 28412
Phone: 910-799-2262
Fax: 910-799-2943
www.portcityspine.com