

# F A X S H E E T

Date: 09/09/2025 11:29:39 AM  
To:  
Subject: Referrals  
Fax Number: [REDACTED]  
To Company:  
From Name: Collins, Jenna L  
From Company: [REDACTED]  
From Facility: [REDACTED]  
Support Contact:  
Number of Pages(s): 19

**The documents accompanying this telecopy transmission contain confidential information belonging to the sender that may be legally privileged. The information is intended only for the use of the individual(s) or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone at the number above to arrange for return of the original document to us. Thank you.**

**REFERRAL**

Karen Root, APRN  
Nurse Practitioner  
**Lyons Family Care**

1221 W NOBLE ST , LYONS, KS-67554-3026  
Tel: 620-257-5124 Fax: 620-257-5128

Date: 09/09/2025

**Patient Information:**

Patient Name: Arthur D Hemry  
Patient DOB: [REDACTED]  
Patient Insurance: BCBS OF KANSAS  
Patient Subscriber No: [REDACTED]  
Patient Address: [REDACTED]  
Patient Phone: [REDACTED]  
Patient Work Phone: [REDACTED]  
Patient Cell Phone: [REDACTED]  
Patient SSN: [REDACTED]

**Insurance Information**

Insurance Name: [REDACTED]  
Subscriber Name: [REDACTED]  
Subscriber DOB: [REDACTED]  
Subscriber No: [REDACTED]  
Subscriber Group No: [REDACTED]  
Subscriber Address: [REDACTED]  
Subscriber Phone: [REDACTED]

**Referral From Information:**

Provider Name: [REDACTED]  
Provider ID Number: [REDACTED]  
Provider UPIN: [REDACTED]  
Provider NPI: [REDACTED]  
Provider Facility: [REDACTED]  
Provider Speciality: [REDACTED]  
Address1: [REDACTED]  
Address2: [REDACTED]  
City, State, Zip: [REDACTED]  
Phone: [REDACTED]  
Fax: [REDACTED]

**Referral To Information:**

Provider Name: [REDACTED]  
Provider ID Number: [REDACTED]  
Provider UPIN: [REDACTED]  
Provider NPI: [REDACTED]  
Provider Facility: [REDACTED]  
Provider Speciality: Neurosurgery  
Address1: [REDACTED]  
Address2: [REDACTED]  
City, State, Zip: [REDACTED]  
Phone: [REDACTED]  
Appt. Date/Time: [REDACTED]  
Fax: [REDACTED]

Facility Tax ID Number: [REDACTED]

## REFERRAL

Karen Root, APRN  
Nurse Practitioner

**Lyons Family Care**

1221 W NOBLE ST , LYONS, KS-67554-3026

Tel: 620-257-5124 Fax: 620-257-5128

**Reason For Referral:**

**Authorization No:**

Reason: Hutchinson  
Diagnosis: M50.90 - Cervical disc disease  
E/M Codes:  
Procedures:  
Visits Allowed: 0  
Unit Type: V (VISIT)  
Start Date: 09/09/2025  
End Date: 09/09/2026  
Priority: Routine

**Authorization Type:**

**General Notes:**

Collins, Jenna L 09/09/2025 11:25:48 AM CDT >P: 620-662-6000 F: 785-626-8843 faxed to Dr. Abassi

Provider NPI: 1053585836

Electronically signed by Karen Root, APRN on 09/09/2025 at 11:28 AM CDT