Lake County Physicians' Association

Specialist Additional Referral Request Form

Request for Additional Services: If follow up office visits or any test/procedures are recommended by specialist please return this form with the following information filled out and the specialist notes attached.

Date:_____

Patientôs Name:_____ Patientôs DOB:_____

Patientôs Insurance ID: _____ Patientôs PCP:_____

Insurance Plan:_____

Clinical Dx Code (ICD-10):_____
Description: _____
CPT Code(s):_____
Place of Service:_____
# of Additional Visits Requested:_____
Additional Information:_____
_____
_____
_____
_____
Next Appointment Scheduled For:_____
Date Faxed Back to PCP:_____ By:_____

* Specialist Notes Must Be Faxed Back to PCP within 1 Week from Date of Service*