

Coastal Cardiovascular & Thoracic Associates, P.A.

PRACTICE LIMITED TO CARDIOVASCULAR AND THORACIC SURGERY
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REFERRAL FORM SURGICAL CONSULTATION ONLY

We do *not* participate with *all* insurances, therefore, please **verify prior** to referring patient. Thank you.

Please **print** in all requested fields:

Patient Name: _____ DOB: _____ - _____ - _____

Mailing Address: _____ SS #: _____ / _____ / _____

City, State, Zip: _____ Phone: (_____) _____ - _____

Primary Insurance: _____ Policy #: _____

Insured: _____ Group #: _____ Phone: (_____) _____ - _____

Secondary Insurance: _____ Policy #: _____

Insured: _____ Group #: _____ Phone: (_____) _____ - _____

Reason for referral/diagnosis: _____
(Be descriptive) (ICD-9)

Physician Requested(circle one): Dr. Wuamett Dr. Johnson Dr. Holt Dr. Litke Dr. Desai

Referring Physician: _____ NPI #: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Primary/Family Physician: _____ NPI #: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Cardiologist: _____ NPI #: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Authorization # (if applicable): _____

In order for our Scheduling Department to schedule an appointment, please fax appropriate diagnostic testing (completed within the last 3-months) with this completed referral form and a copy of patient's insurance card to--

**ATTN: SCHEDULING
(386) 673-0308**

Once appointment has been scheduled, we will contact patient and your office will be notified via fax. If you have any questions, you may call Scheduling at extension 111.