

Referral to Humboldt Neurological Medical Group, Inc.

Date: _____

Phone: (707) 443-9385 Ext. 100

Fax: (707) 443-2847

Urgent Referral. Please Expedite. (Please note: Our physicians will review the referral on an urgent basis, and will advise referral clerk how to proceed. If your provider would like, they may call our front desk at (707) 443-9385, and speak directly with one of our physicians.)

Referring Provider _____ Supervising Physician _____

Referring Office Contact _____ Phone _____ Fax _____

Primary Care Provider _____ Legal Guardian Name (minors) _____

Patient Name _____ DOB _____ Previous patient of Humboldt Neurology? Y N

Maiden or Previous Last Name _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

1st Contact Phone _____ 2nd Contact Phone _____

Primary Insurance _____ Secondary Insurance _____

If Medi-Cal, please provide ID # _____ Please include copy of front and back of patient's insurance card(s).

Check here if Work Comp. Authorization Hardcopy MUST BE INCLUDED WITH REFERRAL in order to proceed.

Worker's Comp Insurance _____ Adjuster _____ Date of Injury _____

Phone _____ Address _____ Claim # _____

Requested Service(s): Please call our billing department @ 707-443-9542 for any additional codes

- o Neurology Consult 99245
- o Sleep Consult 99245
- o EMG RUE LUE RLE LLE *Varies*
- o NCV RUE LUE RLE LLE *Varies*
- o EEG Routine *Please attach EEG form.* 95816
- o EEG Sleep Deprived *Please attach EEG form.* 95819

Signs/Symptoms/Diagnosis _____

Please attach with this referral in order to proceed: insurance card copies, any necessary insurance authorizations, EEG form (if ordering EEG), relevant chart notes, imaging reports, hospital records and any previous neurology records. Pending referrals (any that do not have the requested information) will only be held two weeks; then a new referral will be required.

We will contact the patient to schedule. Thank you for your referral.

Appointment Date _____ Time _____ a.m./p.m. Provider _____