Ophthalmic *Plastic Surgery, Inc.*

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OPS PHYSICIAN REFERRAL FORM

fax to (317) 817.1737 or email to fax@opsindy.com

PHYSICIAN INFORMATION

Date: ____________________ Referred by: ____________________

To: ____________________

Address: ____________________

NPI#: ____________________

Secure email address: ____________________

Phone#: ____________________

Fax#: ____________________

Has patient previously been seen by OPS? ❑ Yes ❑ No

If yes, by which physician: ____________________

REASON FOR CONSULTATION

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PATIENT INFORMATION

YOU CAN SEND YOUR DEMOGRAPHIC SHEET IF IT COVERS EVERYTHING LISTED.

Patient's Name: ____________________

DOB: ____________________ SS#: ____________________

Address: ____________________

City: ____________________ State: ________ ZIP: ____________________

Patient Phone Number: ____________________

Work Phone: ____________________

Cell Phone: ____________________

Email address: ____________________

ONLY to be used to communicate with patient regarding appointments

INSURANCE INFORMATION

WE PREFER A COPY OF THE CARD, FRONT AND BACK

Insurance Plan: ____________________

ID# ____________________ Effective Date: ____________________

Is Auth/Pre-Cert Required? ❑ Yes ❑ No If yes, # ____________________

Secondary Ins: ____________________

ID# ____________________

Effective Date: ____________________

NOTICE OF CONFIDENTIALITY: THIS FORM IS CONFIDENTIAL AND IS INTENDED SOLELY FOR THE PERSON INDICATED ABOVE. IF YOU ARE NOT THE INTENDED PERSON, YOU ARE HEREBY NOTIFIED OF THE CONFIDENTIAL NATURE OF THIS FORM AND THAT YOU ARE NOT ENTITLED TO READ COPY OR OTHERWISE DISSEMINATE ANY OF THE INFORMATION DISCLOSED IN THIS FORM.

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