**Ophthalmic** *Plastic Surgery, Inc.*

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# OPS PHYSICIAN REFERRAL FORM

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

## REFERRING 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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

## 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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