Masdon ENT & Facial Plastic Surgery

Masdon ENT Hearing Aids

JAMES L. MASDON, M.D. / HANNAH NIXON, AU.D. / COREY CAHILL, FNP

Please complete this form and fax it to us along with the patient's records. We will call the patient to set up an appointment and fax this form back to you with their appointment date and time for your records.

Fax—(256) 840-4584

REFERRAL FORM

Date: _____

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell: _____ Work: _____

Referring Physician: _____ NPI Number: _____

Office Phone: _____ Fax Number: _____

REASON FOR VISIT: _____

Does Insurance Require a Referral? ☐ Yes ☐ No Referral Authorization Number: _____

Primary Insurance: _____

Contract Number: _____ Group Number: _____

Name of Insured: _____ Date of Birth: _____

Secondary Insurance: _____

Contract Number: _____ Group Number: _____

Name of Insured: _____ Date of Birth: _____

PLEASE ATTACH:

- REFERRAL IF REQUIRED BY INSURANCE
- MOST RECENT OFFICE VISIT AND ANY RELEVANT TESTING PERTAINING TO THEIR DIAGNOSIS

APPOINTMENT DATE & TIME: _____

Thank you for your referral.

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