

PEACE OF MIND, INC.

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Lillington, NC 27546-2088

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Fax: (910) 814-2167
info@peace-of-mind-inc.com

REFERRAL FORM

Date: _____

Patient's Name: _____

Parent or Legal Guardian's Name: _____

E-mail address : _____

Home Phone #: _____ Cell # _____ Work # _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS# _____

Insurance Company: _____

Insurance Company Phone #: _____

Policy # or ID: _____ Policy Group #: _____

Policy Holder's Name: _____ SS# _____

Policy Holder's Address: _____

Policy Holder's Phone #: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Physician's Name /Signature: _____

MD Telephone/Fax Number/E-mail: _____

Carolina Access Primary Care/NPI Provider Number: _____

Presenting Problem/Reason for Referral: _____

Please fax completed referral forms along with HIPAA compliant cover page to:

(910) 814-2167

OFFICE USE ONLY:

Insurance Authorization: _____

01/2008