Southland Pediatric Therapy

Patient Referral Information Form

We accept the following insurances: GA and S.C. Medicaid, Amerigroup, CareSource, PeachState, WellCare, Ambetter, Aetna, BCBS of Ga, BCBS of S.C., Cigna, Coventry, Tricare and United Healthcare. Please complete the requested information below and fax back to our office at 912-335-2377. Please also fax over copy of insurance card(front & back), any progress notes, prescription and demographics.

Referred for: OT PT Speech Date:_____ Diagnosis:_____
Referring physician:_____Primary Physician:_____
Reason for referral:_____

Patient Information:
Patient Name:_____Sex: Male Female
DOB:_____Patient SS#: _____
Home Address:_____
City:_____State:_____Zip:_____
Guardian's name:_____Relationship:_____
Home phone #:_____Work #_____Cell#_____

Primary Insurance Information:
Payor:_____Plan_____Phone #:_____
Policy#_____Group#_____

Policy Holder Information:
Subscriber Name:_____Relationship to patient:_____
Subscriber DOB:_____Gender:_____Employer:_____
Address and Phone # (if different than Patient)_____

Secondary Insurance Information:
Payor:_____Plan_____Phone #:_____
Policy#_____Group#_____

Policy Holder Information:
Subscriber Name:_____Relationship to patient:_____
Subscriber DOB:_____Gender:_____Employer:_____
Address and Phone # (if different than Patient)_____

Thank you for referring this patient to our practice.

For office use:
Patient has been notified/ scheduled: Y N Appointment Date/Time:_____

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"To broaden the lives of children through caring and therapeutic services"
www.southlandtherapy.com