

PHONE: 304-598-4855

FAX: 304-598-4733

PO Box 9156, Morgantown, WV 26506-9156

Date of Referral: ____/____/____

EPIC: 21012130

Requesting Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

INSURANCE INFORMATION Morgantown (In Person) Summersville (Telemedicine)**PATIENT INFORMATION**

Name: (Last) _____ (First) _____ (MI) _____

DOB: ____/____/____ Social Security #: _____ MALE FEMALE

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

PATIENT DOCUMENTS WHIN EPIC**If not, FAX or MAIL the following:** Referral letter Last progress note Current labs Scan / X-ray pathology reports Copy of insurance card