



**Physician Express Referral Fax:**

**From Dr.** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Patient:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Please call me or patient (circle one) back around \_\_\_\_\_ am/pm**  
**We will fax you an appointment confirmation.**

**Referral for:** \_\_\_\_\_ **(doctor name or specialty)**

**DX:** \_\_\_\_\_

**Patient** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SSN#** \_\_\_\_\_

**Responsible Party** \_\_\_\_\_ **SSN#** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **Pol#** \_\_\_\_\_

**Group#** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **Pol#** \_\_\_\_\_

**Group#** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**If Workers' Comp** \_\_\_\_\_ **yes/no** \_\_\_\_\_ **Pol#** \_\_\_\_\_

**Carrier** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Employer** \_\_\_\_\_ **DOA** \_\_\_\_\_

**Claim#** \_\_\_\_\_ **Employer phone#** \_\_\_\_\_

**If Other responsible** \_\_\_\_\_

\_\_\_\_\_

**Your name** \_\_\_\_\_

**Fax to: 479-709-7030**

**Enclose face sheet and all other information (chart).**

**Tricare/AR/OK Medicaid must have referrals prior to appt.**

**We only accept Arkansas and Oklahoma workers' comp.**