



Madison County Memorial Hospital

REFERRAL FOR WELLNESS CLINICAL SERVICES

Date: _____ Number of pages (including this page) _____

To: Madison County Memorial Hospital
Outpatient Authorization Department

Case# 800-022-1012
Claim# 800-022-1004

From: _____ Phone: _____ Fax: _____

Patient Information:

Patient's Name: _____
(Last) (First)

Date of Birth: _____ Phone Number: _____ Cell: _____

Referring Physician/Provider: _____ Phone: _____

Service(s) Requested: ☐ Wound clinic ☐ Infusion clinic

Indication(s) for Referral/Completion:

Attachments: (Please include the following documentation with your referral)

- ☐ Copy of Insurance card
- ☐ M&P/ Last Office Visit Note
- ☐ Medication List
- ☐ CPT code/Procedure Code
- ☐ Yes, the patient is currently taking anticoagulant medications.
- ☐ Yes, the patient has a pacemaker.

NOTE: We will call the patient after insurance verification is completed to schedule an appointment.

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