onecall®

PHYSICIAN SERVICES | REFERRAL FORM

*Please choose one
☐ Needs Autorization
☐ Already Autorized

*Please choose one
☐ Needs Scheduling
☐ Already Scheduled

*Fields marked with an asterisk are required.
(Note: Claim # is required.)
Please provide as much info as possible to expedite the process.

Authorization Request for: ☐ Radiology ☐ EMG & NCS ☐ DME ☐ Physical Therapy ☐ Telerehab

☐ Language Services _____ ☐ Other _____

☐ Transportation: ☐ Ambulatory/Sedan ☐ Wheelchair ☐ Non-emergency Ambulance
☐ Other _____

Notes/Location: _____

*Patient First & Last Name: _____ *Gender: ☐ M ☐ F

*Address: _____ SSN: _____

*Primary Phone: _____ Other Phone: _____ *D.O.B.: _____

Secondary Phone: _____ Fax: _____ Date of Injury: _____

Employer: _____ Employer Phone: _____

*Insurance Co.: _____ *Claim#: _____
(If available, or else SS#)

Other information, if Available

Insurance Co. Address: _____

Adjuster Information *(if available)*:

Name: _____

Email: _____

Phone: _____

Fax: _____

Practice Name: _____ Office Contact: _____

Treating Physician: _____ Office Contact Phone: _____

Diagnosis 1: _____ Email: _____

Diagnosis 2: _____ ICD9 Code 1: _____

ICD9 Code 2: _____

Clinical Information/Special Instructions
(e.g. open/closed machine, etc.): _____

Radiology/ EMG & NCS Exam Type: ☐ MRI ☐ MRA ☐ CT ☐ EMG & NCS ☐ W/ & W/O Contrast ☐ W/O Contrast
☐ Extended Radiology *(please specify)* _____ ☐ W/ Contrast

Body Part: _____ ☐ RT ☐ LT CPT: _____

Body Part: _____ ☐ RT ☐ LT CPT: _____

Body Part: _____ ☐ RT ☐ LT CPT: _____

DME/ Other Type/Body Part: _____

PT Duration *(weeks)*: _____ Frequency *(times/wk)*: _____ Body Part: _____ ☐ RT ☐ LT

If Already Scheduled Provider Name: _____ Provider Phone: _____

Date of Appt.: _____ Time of Appt.: _____

PATIENT NOTES, PRESCRIPTION AND A COPY OF WORKER COMPENSATION PANEL (if applicable) MUST ACCOMPANY THIS AUTHORIZATION REQUEST.

PLEASE FAX FORM TO: 571.446.2061 OR EMAIL TO EZauth_ScheduleOnly@onecallcm.com

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