MS EYE CARE

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CONSULT REQUEST FOR OPINION

DATE: ____ /____ /_____ **PERSON SENDING REQUEST:** _____

FROM: _____ **UPIN#** _____ **NPI#** _____

ADDRESS: _____

TELEPHONE#: _____-_____-_____ **FAX#:** _____-_____-_____

PATIENT NAME: _____ **DATE OF BIRTH:** ____ /____ /_____

STREET ADDRESS: _____ **HOME PHONE#:** _____-_____-_____

CITY: _____ **ALTERNATE PHONE#:** _____-_____-_____

VISIT RELATED TO W/C OR AUTO ACCIDENT? ☐ NO ☐ YES **IF YES, EXPLAIN BELOW:**

_____

REASON FOR OPINION: _____

_____

INSURANCE: ☐ YES ☐ NO **TYPE (CIRCLE ONE):** PPO HMO POS EPO _____

INSURANCE PLAN:

COMPANY NAME: _____

ADDITIONAL INFORMATION: _____

_____

_____

PLEASE FAX THIS COMPLETED FORM TO 713-942-0265 ALONG WITH THE PATIENTS RECORDS, YOUR OFFICE DEMOGRAPHICS SHEET AND A COPY OF THE FRONT AND BACK OF THEIR INSURANCE CARD.

THANKS!!
DR. TANG'S OFFICE