

# Adult Specialist Request



## OPTIONS TO REQUEST AN APPOINTMENT:

- Direct Messaging/EHR: [Referral@Direct.VidantHealth.com](mailto:Referral@Direct.VidantHealth.com)
- Fax: 252-847-3337 Phone: 252-847-0097
- Urgent

Please include complete office notes including labs and the physician referral note. If you have a stat appointment request, it is best to call the physician's office directly. For emergencies, send the patient to the closest Emergency Department.

Referral# \_\_\_\_\_ MRN# \_\_\_\_\_

Referring office _____	Referring office phone _____
Office contact _____	Contact's fax _____
Contact's email _____	Direct message address _____
Referring provider _____	Circle MD DO NP PA NPI # _____
For PAs and NPs – supervising physician _____	NPI # _____

Faxed on \_\_\_\_\_ Requested specialty \_\_\_\_\_

First available OR Requested provider \_\_\_\_\_

Preferred Location/Satellite Choice \_\_\_\_\_

Please explain reason for the referral/diagnosis \_\_\_\_\_

Please check the box for any diagnostic test already performed:

- MRI
- ECHO
- PFT
- CT
- X-Ray
- OTHER

Patient name \_\_\_\_\_ Patient birth date \_\_\_\_\_

Patient address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender  Male  Female Race \_\_\_\_\_ SSN \_\_\_\_\_

Home phone \_\_\_\_\_ Alternate phone \_\_\_\_\_

Preferred language  English  Spanish  Other \_\_\_\_\_  Translator needed

Location where test was performed:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Insurance:  BCBS  Medicare  Medicaid  Medicaid CA  Tricare Prime\*  Tricare Select  
 Self-pay  Other \_\_\_\_\_

### Additional Notes:

Pre-auth needed: Yes  No

Auth #: \_\_\_\_\_

Dates covered: \_\_\_\_\_

No. of visits covered: \_\_\_\_\_

Primary insurance # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary insurance \_\_\_\_\_ Group NPI for authorization \_\_\_\_\_

Dates covered \_\_\_\_\_ # Visits covered \_\_\_\_\_

*\*Appointment will not be scheduled until Tricare Prime, Gateway & BCBS Medicare HMO authorization is received*

## VIDANT PHYSICIAN REFERRAL SERVICE USE ONLY

Appointment date	Appointment time	
Specialist name	MD DO NP PA	
Office name	Phone	Fax
Office address		
Patient notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Specialty Office <input type="checkbox"/> VM <input type="checkbox"/> NVM Mail		<input type="checkbox"/> New patient