



Gastroenterology
Phone: 910-341-3343

1202 Medical Center Drive
Wilmington, NC 28401

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Leland, NC 28451

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FAX REFERRAL FORM WITH RECORDS TO: 910-341-1900

Patient Name: _____ DOB: ____/____/____

SS #:----- Phone#: (H)_____(Work/Cell)_____

Address:_____

Referring MD:_____ Phone #:_____ Fax #:_____

Address:_____ NPI:_____

Patient's PCP:_____ Phone #:_____

Insurance Co: Primary:_____ Secondary:_____

Authorization Required: Yes No Authorization #:_____

ID #:_____ Group #:_____

Subscriber's Name:_____ Employers Name:_____

REASON FOR REFERRAL: _____

REQUIRED: Copy of insurance cards, office notes, X-Ray, MRI, or CT scan reports.

******PATIENT MUST BRING ALL XRAY, CT OR MRI FILMS TO APPOINTMENT******

******TRICARE PRIME PATIENTS' AUTHORIZATIONS NEED TO BE FAXED WITH THIS REFERRAL******

PLEASE ALLOW TWO TO THREE BUSINESS DAYS FOR RECORDS TO BE PROCESSED BEFORE THE APPOINTMENT CAN BE MADE.

ANY QUESTIONS CONTACT 910-341-3343

THANK YOU FOR ALLOWING WILMINGTON HEALTH TO SERVE YOUR HEALTHCARE NEEDS