Jeffrey Culp, MD
Allergy/ Immunology
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Phone: 910-796-7545
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PATIENT REFERRAL FORM

**** REFERRAL FORM MUST BE FILLED OUT COMPLETELY AND FAXED TO 910-341-1900 BEFORE ANY APPOINTMENT CAN BE MADE.**

Patient Name: _____ DOB: ____/____/_____

SS#: ____- ____ -____ Phone: _____ Cell: _____

Address: _____

Referring MD: _____ Phone: _____ Fax: _____

Address: _____ NPI: _____

Patients PCP: _____ Phone: _____

Insurance Company Information:

Authorization Required? YES NO -- Authorization #: _____

Primary _____ ID#: _____ Group# _____

Secondary: _____ ID#: _____ Group# _____

Subscriber's Name: _____ DOB: _____

REASON FOR REFERRAL: _____

REQUIRED: Copy of ins cards, Recent office notes, Relevant X-rays, Labs, MRI or CT scan reports, and Current Medication list. Please instruct Patient to arrive 15 minutes prior to appointment time. If they are late they may be asked to reschedule. Please contact us with any question at 910-796-7545.