760 W. Eisenhower Pkwy, STE.200
Ann Arbor, MI 48103
Office: 734.213.3700
Fax: 734.213.3706
www.michiganveincare.com

PATIENT REFERRAL

Patient Name: _____
First Middle Initial Last

Date of Birth: _____ Patient's Phone: _____

Address: _____

City/State/Zip: _____

Preferred Contact Name and Number (if other than patient):_____
_____

Diagnosis ICD 10:_____
Symptoms:_____
_____

Primary Insurance Provider: _____ Subscriber ID_____

Secondary Insurance Provider: _____ Subscriber ID_____

Referred by:

Physician's name (please print):_____
First Last

Physician's signature: _____

NPI:_____ Phone: _____

Address: _____

City, State, Zip: _____

DOCUMENTATION REQUESTED

(PLEASE MARK ATTACHED DOCUMENTS)

☐ Relevant Clinical Notes **(History & Physical, Imaging and Lab results, History of Compression Use)**

☐ Copy of Insurance Card ☐ Insurance Authorization Information (If required)

CONFIDENTIALITY NOTICE