Wrightington Rheumatology, LLC
4849 Paulsen Street, Suite 209, Savannah, GA 31405
Phone: (912) 352-7960. Fax: (912) 335-8907

Request for Consultation or Transfer of Care for Rheumatology Services

The following information is required in order to schedule an appointment at our office:

1. Requesting physician's office note
2. Biopsy, laboratory, and radiology reports relevant to the request
3. A legible copy of the insurance card(s)
4. Verification of patient's benefits for pre-certification

PLEASE CHECK ONE: Consultation Transfer of Care

Today's Date: _____

Patient's Name: _____

SS #_____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Requesting Dr. (full name): _____NPI: _____

Requesting physician's office fax #: _____ Phone #: _____

Requesting physician's office contact _____

Reason for Request: _____

Primary Insurance: _____ Policy #: _____

Insured Name: _____

Referral authorization required? _____ YES _____ NO

If Yes, Authorization Number: _____

Secondary Insurance: _____ Policy #: _____

Insured Name: _____

_____ _____
Requesting Physician or Authorized Designee's Signature **Date**

Appointment information: Wrightington Rheumatology use only

Date: Time:

Please fax this form to (912)-335-8907