

BriefMD Medical Office

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Referral Authorization / Confirmation Form

For fax response to specialists after referral request submission or insurance authorization update.

REFERRAL REQUEST UPDATE

Date Faxed

Current Update

Submitted to Insurance

Awaiting Insurance Determination

Authorization Received

Additional Information Requested

PATIENT INFORMATION

Patient Name

Date of Birth

Insurance Plan

Insurance ID #

PCP

Referral Requested By

SPECIALIST INFORMATION

Specialist / Facility

Specialty

Specialist NPI

Specialist Fax

Specialist Phone

Place of Service

Office

Hospital

Telehealth

REFERRAL AUTHORIZATION DETAILS

Referral / Authorization #

Approved # of Visits

Effective Date

Expiration Date

ICD-10 / Diagnosis

Appointment Requested Date

Appointment Confirmed Date

DOCUMENTS INCLUDED

Referral Order

Office Notes

Labs

Imaging

Medication List

Demographics

Other:

NOTES / SPECIAL INSTRUCTIONS

BRIEFMD REFERRAL COORDINATION TEAM

Coordinator Name

Signature

Date

*CONFIDENTIALITY NOTICE: This fax contains confidential medical information intended only for the recipient.
If received in error, please notify BriefMD Medical Office immediately and destroy all copies.*