OCN OPHTHALMIC CONSULTANTS NORTHWEST

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REFERRAL REQUEST FORM

REQUESTED SERVICES:

☐ Evaluate and Treat ☐ Second Opinion: Patient will be returned to Referring Provider

☐ Co-Management ☐ Other: _____

☐ Urgent ☐ Routine _____

PATIENT INFORMATION

Patient Name: _____

Patient Home Phone: _____ Mobile: _____

DOB: _____ SSN: _____

DIAGNOSIS / REASON FOR REFERRAL: _____

_____

Interpreter Required? ☐ Yes ☐ No If YES, what language?: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ ID/Member #: _____

Secondary Insurance Name: _____ ID/Member #: _____

Subscriber Name: ☐ Patient ☐ Other: _____

***PLEASE NOTE:** OCN is not contracted with Molina Healthcare of WA or Community Health Plan of WA. Please contact the patient's PCP for authorization. For more information, please contact our Referral Coordinator at (206) 812.2991

REFERRING PROVIDER INFORMATION

Name of Referring Provider: _____

Contact Phone: _____ NPI: _____

NOTES: _____

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