

Physician Referral Form Fax Referrals to: (317) 872-6865

	REFERRING PH	YSICIAN INFORMATIO	ON
Date:		Contact Person Name:	
Referring Office (Practice Name):		_ Contact Phone #:	
Referring MD:		_ Fax Phone #:	
	PATIENT	INFORMATION	
Patient Name:		Home Phone #:	
Date of Birth:		Alternate Phone #:	
Insurance Company:		_ Policy #:	
Policy Holder Name:			
			☐ Hand ☐ Wrist ☐ Elbow ☐ Shoulder
Prior Testing/Surgery for this pro			
☐ X-ray ☐ Fluoroscopy	☐ MRI ☐ Angiogram	☐ CT	□ EMG
	Patient face sheet or demograp	ohic form is appreciated bu	it not required.
Indiana Hand to Shoulder Center Physician Requested:			
☐ William Kleinman, MD☐ Hill Hastings, MD☐ Thomas Fischer, MD	☐ James Creighton, MD☐ Alexander Mih, MD☐ Robert Baltera, MD	☐ Jeffrey Greenberg,☐ F. Thomas Kaplan☐ Gregory Merrell, M	n, MD
Preferred Location:			
Avon Fishers	☐ Indianapolis-Downtown ☐ Indianapolis-Northside	☐ Kokomo ☐ Lafayette	☐ Terre Haute
INDIANA H	AND TO SHOULDER CENT	ER CONTACT INFOR	MATION (All Locations)
Referral Coordinator: Diane Lawle	er	Contact Phone #:	<u>(317) 870-5207</u>
Referral Coordinator (back up): <u>Jessica Par</u>	rrott	Contact Phone #:	(317) 870-5213
Please call our Referral Coordinator with any concerns or questions regarding the referral process.			
FOR INDIANA HAND TO SHOULI (form will be faxed back to referring		scheduled)	
Appointment Date:		_ Appointment Time:	
Physician:		Location:	

WE ACCEPT THE FOLLOWING INSURANCE CARRIERS:

- Advantage (SIHO, Suburban Health, St V CMO)
- Aetna
- Anthem
- Anthem/HIP
- Humana/Choice Care
- IU Health Plan/Healthsmart
- Cigna
- Encore
- Indiana Health Network
- Medicare
- Multiplan
- Ohio Bureau of Workers' Comp
- Sagamore
- Tricare
- United Healthcare