

EXTERNAL PHYSICIAN REFERRAL FORM

PHONE: 216-957-3222

FAX: 216-778-2700

**PLEASE PRINT ALL INFORMATION CLEARLY.
ANY ILLEGIBLE FORMS MAY NOT BE PROCESSED**

**We appreciate your referrals to the MetroHealth System
Please allow 7-10 business days before calling for appointment**

REQUIRED INFORMATION:

Date: _____
Provider: _____ **NPI:** _____
Provider Phone: _____
Provider Address, Zip Code _____

Patient Name: _____
Patient Date of Birth: _____ **Patient Phone:** _____
Patient Address: _____
Insurance Company ID Number: _____
Insurance Company Name: _____

Referring to ** Specialty Physician/Department/Procedure/Radiology (With or W/O Contrast):

**Diagnosis or Reason for Referral/ICD Code:

Please forward your progress note with subjective and objective indications for the requested test. **

****Attach prior approval letter from insurance co. if needed** ****

Make copies for future referral requests**