

Referral To Mayo Clinic Health System - Franciscan Healthcare

Fax form with copy of insurance card (front & back) and supporting provider note - in order to process

NSURANCE INFORMATION Insurance Plan Name: Subscriber Number for Insurance: Subscriber Name: Specialty Requested Specialt	•	Last)			Date of Birth
INSURANCE INFORMATION Insurance Plan Name: Subscriber Number for Insurance: Subscriber Name: Guarantor DOB: Subscriber Name: Guarantor: Address: APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested Department Requested Speciality Requested Provider Requested Appointment Timeline: Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	Address				Gender
INSURANCE INFORMATION Insurance Plan Name: Subscriber Number for Insurance: Guarantor DOB: Subscriber Name: Guarantor: Address: APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested Department Requested Specialty Requested Provider Requested Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facility Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE					M or F
Subscriber Number for Insurance: Guarantor DOB: Subscriber Name: Guarantor: Address: APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested	City, State, Zip		Home Phone		Other Phone
Subscriber Number for Insurance: Subscriber Number for Insurance: Guarantor DOB: Subscriber Name: Guarantor: Address: APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested Department Requested Specialty Requested Provider Requested Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE					
Subscriber Number for Insurance: Subscriber Name: Guarantor: Address: APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested Department Requested Specialty Requested Provider Requested Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE		TION			
APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested Department Requested Specialty Requested Provider Requested Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	Insurance Plan Name:		Guarantor Name:		
APPOINTMENT REQUEST INFORMATION (must be filled out) Location Requested Department Requested Specialty Requested Provider Requested Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	Subscriber Number for Insu	rance:	Guarantor DOB:		
Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	Subscriber Name:		Guarantor: Addre	ss:	
Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE			<u>. </u>		
Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	APPOINTMENT REQI	HEST INFORMATION (mus	et he filled out)		
Appointment Timeline: Urgent (<3 days) 4-14 days Routine Other Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE		,		ted	Provider Requested
Chief Complaint (Diagnosis & ICD9): Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	·				
Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) REFERRING PROVIDER INFORMATION Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE			4-14 days	Routine	Other
Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	Total Ordanada (in	" C' Taba OVT Nouro	St Strate EEC E		
Referring Facilty Name Referring Provider Name Person Completing Form Phone for Questions Fax Number Email Address: ORDER SIGNATURE	Specific Tests Ordered: (ie.	Cardiac: Stress Echo, GXT Neuro:	: Sleep Study, EEG F	Radiology: MRI	l, CT, US)
Email Address: ORDER SIGNATURE			: Sleep Study, EEG F	Radiology: MRI	l, CT, US)
	REFERRING PROVID		: Sleep Study, EEG F	Radiology: MRI	, CT, US)
ORDER SIGNATURE	REFERRING PROVID	DER INFORMATION			
	REFERRING PROVID Referring Facilty Name Referring Provider Name	DER INFORMATION			
	REFERRING PROVID Referring Facilty Name Referring Provider Name	DER INFORMATION			
	REFERRING PROVID Referring Facilty Name Referring Provider Name	DER INFORMATION			
Ordering Provider Signature For Diagnostic or Radiology Orders Date Tin	REFERRING PROVID Referring Facilty Name Referring Provider Name Email Address:	DER INFORMATION			
Ordering Provider Signature For Diagnostic or Radiology Orders Date Tin	REFERRING PROVID Referring Facilty Name Referring Provider Name Email Address:	DER INFORMATION			
	REFERRING PROVID Referring Facilty Name Referring Provider Name Email Address: ORDER SIGNATURE	Person Completing Form	Phone for Questic	ons 	Fax Number
	REFERRING PROVID Referring Facilty Name Referring Provider Name Email Address: ORDER SIGNATURE	Person Completing Form	Phone for Questic	ons 	Fax Number