sōna DERMATOLOGY & MEDSPA

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PROVIDER REFERRAL TO DERMATOLOGIST

Dear referring provider, please note that this form is provided as a simple way for you to refer someone to our office. It is not intended to replace any electronic referral request or prior authorization process required by your patient's insurance company. If that is the case, please follow your patient's insurance requirements for submitting a referral and send it to our office via fax at **704-266-1196** Thank you!

Patient Information:

Name _____ DOB _____ Phone Number _____

Insurance Name & Member ID: _____

Diagnosis/Reason for Referral:

Referring Provider Information:

Physician Name _____ NPI _____ Specialty _____

Phone Number _____ Fax _____ Email Address _____

Address: _____

Special Appointment Requests (Physician/Timeframe): _____

Please FAX the patient's demographic information & applicable office notes and labs to: **704-266-1196**

Person Completing this Form:

Name and Title _____ Phone Number _____ Date _____

Thank you for your referral and please call with any questions!