To all office Staff**,**

We would like to thank you for all of your patient referrals. For your convenience, we have designed a New Patient Referral Form as well as an EMG/EEG Referral form. These forms are meant to cut down on wait times to schedule a patient. For new patient referrals, please fill out the form and fax it along with the patient's **demographic information**, **insurance card(s)** and all **relevant records and testing results**. For an EMG or EEG referral, please fill out the form, which also serves as the order, and fax it along with the patient's **insurance card(s).** Any referral sent without records will not be processed until records are received.

Please inform patients to call our office 10 business days after referrals are sent to schedule appointment.

Again, thank you very much for your referrals. If you have any questions, please feel free to contact our office at (812) 330-0303.

Sincerely,

Scheduling Department of Neurology Specialists

Bloomington Office
813 W 2nd Street Bloomington, IN 47403
Phone (812) 330-0303
Fax (812) 330-0404

Jamie Bales, M.D.
Brian Moore, M.D.
Sonia Pruett, AGPCNP-BC

Bedford Office
2129 W 16th Street, Bedford, IN 47421
2520 Q Street, Bedford, IN 47421
Must Schedule Through Bloomington Office

Brian Moore, M.D.
Sonia Pruett, AGPCNP-BC

Date: _____ Referring Physician: _____NPI#:_____

Office Contact: _____ Phone: _____ Fax#:_____

Patient Name: _____ Preferred Phone: _____ Alt #:_____

Address: _____ City/State/ZIP: _____

DOB: _____ Male or Female:_____ SSN:_____

Email address: _____

****** PLEASE: Fax <u>completed</u> referral form with COPIES of insurance cards, entire medication list, relevant records and diagnostic tests related to the reason for the referral so that we may schedule the client without delay. <u>ALL</u> information <u>MUST</u> be received in order to process referral. Please advise it will take 10 business days to process referral. They may call our office after that time.**
******Thanks! ******

Insurance Type: Medicare, Medicaid, HIP, Work Comp, Commercial/Other, please specify: _____

Id #_____ Group #_____ Insurance Phone#: _____

Do you want this patient scheduled with a specific provider? Yes___ No ____

Jamie C. Bales, M.D.____ Brian H. Moore, M.D.____ Sonia J. Pruett, AGPCNP-BC_____

Diagnosis/reason for referral: _____

Has patient been seen by a neurologist previously? If so, who? _____

If yes, please provide records for our providers to review.

****** For EMG or EEG referral please use attached referral sheet. ******

EMG / EEG REFERRAL SHEET

REFERRING DOCTER NAME AND FAX #

PATIENT NAME

GENDER PHYSICIAN SIGNATURE:

ADDRESS ZIP:

PHONE NUMBER

DATE OF BIRTH

SSN

****INSURANCE NAME****

****POLICY NUMBER****

EMG RU LU RL LL OR EEG

NCV RU LU RL LL DIAGNOSIS

EMG/NCV RU LU RL LL

APPOINTMENT

PLEASE FAX REQUEST TO **812-330-0404**

****It is the patient's responsibility to obtain an explanation of benefits from their insurance carrier to determine if precertification is required for this exam, as well as any "out of pocket" expense associated with this exam. It is also the patient's responsibility to pay any balance due if their insurance carrier does not cover the full amount of this exam. Please include copies of insurance cards if possible. Thanks! ****