WVUPC-MEDICINE AND SPECIALTY OFFICE
4522 MACCORKLE AVE, SE, SUITE 3, CHARLESTON, WV 25304
PHONE (304)720-7305 FAX (304) 720-1381

SPECIALTY REQUESTED:

____DECC / Eating Disorder (Dr. Hani Nahza)

*****APPT WILL BE SCHEDULED ONCE PHYSICIAN SIGNS OFF ON REFERRAL*****

DEMOGRAPHICS

Patients Name: _____ DOB: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

INSURANCE INFORMATION-*MUST HAVE COPY OF CARD ATTACHED-NO MEDICAID or PRIVATE PAY PTS*

Primary Insurance: _____ Managed Care?:_____

*****IF INSURANCE REQUIRES PRIOR AUTHORIZATION/REFERRAL PLEASE SEND PRIOR TO APPOINTMENT*****

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ NPI:_____

Mailing Address:_____

Phone #: _____ Fax #: _____

****Reason for referral****:___Eating Disorder , DECC Team _____

******MUST HAVE COPY OF INSURANCE CARD AND RECORDS PERTAINING TO REASON APPOINTMENT NEEDED-LABS, NOTES, SCANS-FAXED WITH THIS REFERRAL FORM-APPOINTMENT WILL NOT BE MADE WITHOUT THIS INFORMATION******

**** PLEASE NOTIFY YOUR PATIENT OF APPOINTMENT****

We require a 24 hour notice for all cancellations. If the proper notice is not given or the patient does not show for the scheduled appointment, they will be responsible for a $50.00 fee.

APPOINTMENT DATE:_____

APPOINTMENT TIME:_____

WE WILL SEND PATIENT PAPERWORK AND ANY BLOODWORK/TESTS NEEDED PRIOR TO THEIR SCHEDULED APPOINTMENT.

THANK YOU FOR YOUR REFERRAL!