



## Fast Fax Referral

Name of Facility/Practice: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Caller Name/Referral Source: \_\_\_\_\_

## Patient Demographics

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

D.O.B.: \_\_\_\_\_ SS #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Thank you so much for your support and confidence  
through your continued referrals!

Sincerely,  
Fusion HealthCare