

Physician Referral Form

Date: _____

Patient Name: _____ Date of Birth: _____

SSN: _____ - _____ - _____ Home telephone: _____ Cell: _____

Street Address _____

City, State, Zip Code: _____

Reason for Referral:

Insurance or Insurance Card :

- Primary Carrier Name: _____
- Primary Carrier Address: _____
- Primary Carrier Policy Number: _____
- Primary Carrier Group Number: _____
- Primary Carrier Subscriber Name: _____

- Secondary Carrier Name: _____
- Secondary Carrier Address: _____
- Secondary Carrier Policy Number: _____
- Secondary Carrier Group Number: _____
- Secondary Carrier Subscriber Name: _____

Please fax needed records for patient visit to 717-242-7938. If you have questions please call us at 717-242-7939.
Thank you.

Philip L. Rice, M.D., FACS, FACC, FCCP, RPVI
Commonwealth Surgical Services
400 Highland Ave. Lewistown, PA 17044

Telephone 717-242-7939
Facsimile 717-242-7938