LASER EYE SURGERY OF ERIE

311 West 24th Street, Suite 401
Erie, PA 16502
P: (814)455-7591 F: (814)454-1467

Referral Request

**** PLEASE INCLUDE A COPY OF CURRENT INSURANCE CARDS AND LAST OFFICE NOTE WITH THIS REQUEST ****

PatientName:____ Date of Birth: ____________________________

Home Address: ____ City: ________________ State: _________ Zip: ______

Home Phone: _________________________ Cell Phone: _______________________ E-Mail: _________________________

PRIMARY INSURANCE

Name of Insurance: ____ I.D. #: _______________________________

SECONDARY INSURANCE

Name of Insurance: ____ I.D. #: _______________________________

Eyes Affected: OD OS OU

Reason for Referral:

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Problem Duration: ____

Appointment Request: ____

REFERRING PROVIDER INFORMATION

Office Name: ____ Provider Name: _________________________________

Address: ____ City: ________________ State: _________ Zip: ______

Phone: _______________________________________ Fax: _______________________________________

Cataract Referrals Only: Will you be co-managing care for patient: YES _______NO_______

FOR OFFICE USE ONLY

Date Received: ____________________ ☐ Insurance Cards ☐ Office Notes

Appointment Scheduled Date: ______________________________

☐ New Patient Packet Mailed
☐ Patient No showed or Cancelled with no reschedule
☐ Patient Denied Appointment Referral