Atlanta Children's Clinical Center, P.C.

• 455 E Paces Ferry Rd Suite 212 • Atlanta, GA 30305 •
• 404.261.2666 • 404.261.2669 (fax) •
webtriage@atlchildrens.com

Specialist Referral Form

Date:_____

Your insurance may require PreAuthorization for an appointment or procedure with the specialist your physician has referred you to. **Please verify with the specialist that they accept your insurance plan and provide our office with the following information at least 3 business days before your appointment:**

Patient's Name (as it appears on Insurance Card)_____ Date of birth: _____

Please check Primary Care Physician list on insurance card ✓

☐ Megan E. Ference, M.D. ☐ Reshma R. Chugani, M.D.

Insurance Company Name:_____

Patient's Policy ID #: _____ Group #:_____

Guarantor Name:_____ Guarantor Date of birth:_____

Specialist's Name: _____ Specialty:_____

Address (Location of appointment):_____

Phone #: _____ Fax #:_____

Reason for Referral (Diagnosis):_____

Appointment Date: _____ Appointment Time:_____

Please fax this completed form back to our office. **We will not proceed with the referral until we hear from you with the above information.** If your insurance requires a pre-authorization and you do not have one before your appointment with the specialist, your insurance plan may not provide benefits for the specialist's evaluation. We cannot perform insurance preauthorizations retroactively.

For Office use only

Date Referral Completed: _____ Employee: _____

Authorization #: _____ # of Visits Authorized:_____ ☐Referral Not Required Date

Specialist Informed of Authorization: _____ ☐N/A

Date Patient Informed of Authorization: _____ ☐N/A