Lexington Clinic

859.258.4DOC (43620
Fax: 859.258.6118
resref@lexclin.com

REFERRAL FORM

Please fax this form and the required information to 859.258.6118.
For questions regarding this form, please contact us at 859.258.4DOC (4362).

Name of Medical Practice _____

Address _____

Contact Person _____ **Phone** _____ **Fax** _____

Referring Physician _____ **LC Reference #** _____
full name and title

KY License Number _____ **NPI** _____

Department Requested _____ **Provider Requested** _____
(optional)

Reason/DX _____

Preferred time of day ☐ AM ☐ PM **Preferred day of week** _____

Appointment time requested ☐ 1 week ☐ 1 month ☐ 1st available ☐ ASAP *(emergencies only)*

Please include all office notes, labs and imaging reports pertaining to this referral

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Patient Name _____ **LC MRN#** _____

DOB _____ **Age** _____ **SSN** _____ ☐ Male ☐ Female

Address _____

City _____ **State** _____ **Zip code** _____

Home phone _____ **Cell phone** _____

Please send a copy of insurance card along with the fax form.

Insurance _____ **Policy Number:** _____
Please include insurance company, plan and member ID #

Cardholder Name _____ **DOB** _____

For referral services use only

Appointment Date & Time _____ Provider Name _____

Comments _____

_____

_____

_____ New to Lexington Clinic _____ New to Department _____ Updated Demographics

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Does this insurance require prior authorization? ☐ Yes ☐ No *If yes, please obtain using the following information.*

Phone _____ Fax _____

NPI _____ Tax ID # _____