WVU Occupational Medicine
3860 RBCHSC Box 9145
Morgantown, WV 26506-9145
Phone 304-293-3693
Fax 304-293-2629

Referring Provider: ______________________ Contact: ______________________

Specialty: ______________________ Phone: ____________ Fax: ____________

Address: ______________________

Type of Referral:

☐ One-time Consultation (We **DO NOT** assume care.) ☐ Transfer of Care

Patient Name: ______________________ Phone: ____________ Date of Birth: ____________

Address: ______________________

Reason for Referral:

Accepted Diagnosis Codes: ______________________ **PLEASE SEND ALL MEDICAL RECORDS.**

Billing Information:

☐ Worker's Compensation ☐ Insurance

Claim #: ____________ Insurance ID: ____________

Date of Injury: ____________

Carrier Name: ______________________ Phone: ____________ Fax: ____________

Address: ______________________

Claims Manager: ______________________ Authorization #: ______________________

Employer: ______________________

Employer Address: ______________________

Employer Contact: ______________________ Phone: ____________ Fax: ____________

Signature of Referring Provider: ______________________ Date: ____________

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