WVU Medicine

Occupational Medicine Referral

PHONE: **304-293-3693** FAX: **304-293-2629** **PO Box 9145, Morgantown, WV 26506-9145**

Date of Referral: _____/_____/_____

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for referral and/or symptoms: _____

_____ Dx code: _____

REQUESTED SERVICES

☐ **Request for consultation (We do NOT assume care.)**

☐ **Request for referral (We assume care for specified condition.)**

Please send ALL medical records.

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____ Policy ID #: _____

Subscriber's Name: _____ Authorization #: _____

WORKERS COMPENSATION INFORMATION

Workers Compensation Carrier: _____ Date of injury: _____/_____/_____

Address: _____

Claim #: _____ Authorization #: _____

Claims Manager: _____ Phone #: _____

Employer: _____ Phone #: _____