

PHONE: **304-598-4855** / FAX: **304-974-3393**

PO Box 9156, Morgantown, WV 26506-9156

Date of Referral:/			EPI	C: 21012130
Requesting Physician:	Contact Person:			
Phone #:	Fax #:			
Address:				
Reason for Referral:				
INSURANCE INFORMATION				
☐ Morgantown (In Person)	☐ Summersville (Telemedicine	e)		
PATIENT INFORMATION				
Name: (Last)	(First)			(MI)
DOB:/	Social Security #:		☐ MALE	FEMALE
Address:				
Home #:	_ Cell #:	Work #:		
INSURANCE INFORMATION				
Insurance Co. Name:				
Policy ID #:	Subscriber's N	Name:		
PATIENT DOCUMENTS				
□ WVHIN □ EPIC				
If not, FAX or MAIL the following]:			
☐ Referral letter				
☐ Last progress note				
☐ Current labs				
☐ Scan / X-ray pathology report	ts			
☐ Copy of insurance card				