Lapeer Regional Medical Pain Center
Phone# 810-667-5574
Pain Management Referral- fax to 810-667-5910

Last Name __________________________ First Name______________________ male_____ female___

Address________________________ City ________________State_________ zip_______

Patient Information SS# ____________________ Date of Birth_____________ Home Ph#________________ /or other

*Primary Insurance Company Name______________________ Policy # _________________ Group#___________

Phone # for medical benefits____________________ Preauthorization phone#_______________

HMO yes ___ no___ Primary Care Physician_____________ Referral _______________ or authorization#_________

Dates authorized_________ to_________

*Secondary Insurance Company Name____________________ Policy# __________________Group#____________

Phone# for medical benefits__________________ Preauthorization phone # if differs_____________

HMO yes___ no___ Primary Care Physician_____________ Referral_______________ or authorization#___________

Dates authorized_________ to_________

Diagnosis________________________________________ Tentative Scheduled Date____________________

Office Visit/Consult only_______

Consult________________________ and Treat____________________ Procedure_________________________
**

Code______________________________

Ordering Physician______________________________Phone#___________________________

Primary Care Physician or Family Dr____________________________ Phone#__________________________

*Departmental use only*

Consult Benefit________________________

Financial Service Referral ___________________
(Point of Service)

If Injection/ or Procedure_____________________

* Pre-Certification required * YES or NO

Pre-Certification Information-