Patient Referral Request Form

We will not process referrals for clinics that are out of your insurance network. Please check with your insurance before being seen to make sure the clinic is in your network.

All referral requests need to be submitted before the appointment date. Please fill out the form completely. Information left blank will result in a longer processing time or denial for the referral.

Patient Name: _____ Date of Birth: _____

Contact Name: _____ Phone Number: _____

Insurance Company: _____ ID number:_____

Group Number: _____

Primary Doctor at NLP: _____

Name of the clinic you are going to: _____

Address of clinic: _____ City:_____

Phone number of clinic: _____

Have you contacted your insurance company to verify the clinic/specialist is in your network? Yes No If no, please call your insurance company **BEFORE filling out this form**.

Doctor you are seeing: _____

Reason for the appointment (diagnosis if known): _____

Appointment date: _____

Surgery: Yes No If yes, where: _____

For Therapy

Physical Therapy Occupational Therapy Speech Therapy (circle one)

Time period of therapy: _____

How many visits are needed: _____

Please return this form via fax: 651-770-3701 or email ma.staff@NLPediatrics.com