

# ROSE TREE MEDICAL ASSOCIATES

Phone: 610-891-9277 Fax: 610-891-7778

## Referral Request Form

*Please fill in **all** blanks and allow 1 week for processing.*

Patient's Name and Phone #:

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Patient's Insurance Company and ID #:

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Specialist and/or Facility Name and Phone #:

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Provider ID #:

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Procedure being done: *(Please be specific. For example: Mammogram, X-RAY, CT scan, check up, consultation, etc.)*

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Date and Time of Appointment:

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PLEASE NOTE: WE NEED 1 WEEK TO PROCESS A REFERRAL.

- *If you know your insurance requires a referral it is your responsibility to obtain our request forms. (We do not process referrals over the phone). Failing to do so will result in rescheduling your appointment.*