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 #:

Patient's Insurance Company and ID #:

Specialist and/or Facility Name and Phone #:

Provider ID #:

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

Date and Time of Appointment:

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.*