



DUE TO THE VOLUME OF OUTSIDE REFERRALS RECEIVED BY JPS HEALTH NETWORK:

1. Incomplete referral form will be denied and discarded upon receipt
2. Copy of insurance card **is REQUIRED**
3. HMO and Out of Network Insurances will **not** be processed without an accompanying authorization
4. The appointment line phone number is 817 – 702 - 3000

Date: _____

Request for Oral & Maxillofacial Surgery Consult

Diagnosis Code/Reason for Referral _____

Patient Name: _____
Last First MI Suffix

Language: _____ Sex: _____ DOB: _____ SS# _____

Patient's address: _____ City: _____ State: _____ Zip: _____

Patient's phone number: _____

Patient's insurance: _____ Insurance ID#: _____

Subscriber (if not self): Name _____ DOB _____ SS# _____

HMO Authorization#: _____ Out of Network Auth#: _____

Referring Doctor Info

Name: _____ phone: _____

Office Contact Person: _____ Office Fax number: _____

Fax this form and all attachments to (817)702-1117 or e-mail to accresourcctr@jpshealth.org.

Patient Access Center phone number (817)702-1100.

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