Centered in Care
Powered by Pride

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 accresourcectr@jpshealth.org.
Patient Access Center phone number (817)702-1100.