PAIN MANAGEMENT
CENTERS OF AMERICA

Excellence in Interventional Pain Management from a Founder of the Specialty

FOUNDERS OF PMCOA:
Laxmaiah Manchikanti, MD
Mahendra R. Sanapati, MD
www.pmcoa.us

REFERRAL FORM

REQUIRED INFORMATION FOR ALL REFERRALS

REFERRING PROVIDER

Referring Provider:_______________________________________NPI #: _______________________________

Date:__________Referral Contact:_______________________ Referral Contact Email: _____________________

Phone Number:_______________________________ Fax Number: _____________________________________

Address:____________________________ City:__________ State:______ Zip: _____

PATIENT INFORMATION

Name:____ ☐ Male ☐ Female

Address:_____________________________City:______________________State:__________Zip: ____________

Phone Number:___________________________________DOB:______________SSN: _____________________

REASON FOR REFERRAL

Location of Pain:
- ☐ Low back
- ☐ Mid back
- ☐ Neck
- ☐ ________________________

Specific Request
- ☐ Eval and treat
- ☐ Interventional Techniques
- ☐ Spinal Cord Stimulator
- ☐ Intrathecal Infusion System
- ☐ ________________________

Provider requested:
- ☐ First available
- ☐ ______________________
- ☐ ______________________

☐ Diagnosis code ____

Location name:

____

PATIENT INSURANCE INFORMATION

WORKERS COMP? ❒ YES ❒ NO **APPROVED?** ❒ YES ❒ NO **AUTO?** ❒ YES ❒ NO CERT CODE/ATH:__ INSURANCE

CARRIER:____ PHONE NUMBER:______

INSURED'S NAME/RELATIONSHIP:____________________________ DOB____/______/_____ (OF POLICY HOLDER)

EMPLOYER:_________________________ POLICY #:__________________ GROUP #: ______________________

Please send office visit notes, recent MRI, X-ray, CT, NCS, or PT reports along with this form. Please fax all the above information (please see on second page for fax number and contact information).
We will contact you with an appointment date and time. Thank you for your referral.