Submit by Email | Print Form

Washington Medical Group, P.C.

- Use this method to request only referrals for follow up visit with a specialist that you have ***already seen*** for the same problem or diagnosis and you have seen your primary physician for.
- If you wish to obtain a referral to a specialist for a new problem, your insurance requires that you see your Primary Care Physician first for an initial evaluation.
- Fields marked by an asterisk (*) are ***required***, and must be filled in.
- If there are any problems filling your request, we will contact you by email or phone.
- There is a 72 hours processing time for referral request.

E-Mail Address: _____

***Daytime telephone**: _____

***Patient Name:** _____

***Date of Birth:** _____

***Insurance:** _____

***Member id numbe**r:_____

***Primary Care Physician:**_____

***Specialist Physician:**_____

***Specialty:** _____

***Specialist Address:** _____

***Specialist telephone:**_____

Specialist Fax: _____

***Diagnosis or Problem:**_____

***CPT and diagnosis code must be provided for any procedure. Please obtain this information from the specialist office.**

***Please indicate in the comment whether to fax the referral to the specialist office (make sure you provide a fax number) or if you are picking up the referral at our office.**

Comments: _____

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