Northern Arizona ORTHOPAEDICS
Outcomes by HOPCo

NAO REFERRAL FORM

Scheduling: 928.226.2900, Opt 2 | Referral Fax: 928.226.3070

Step 1: Fax this form, along with the patient's referral (if applicable) to fax number above.
Step 2: A Referral Coordinator will contact the patient within 24 hours to schedule an appointment with the appropriate provider.
Step 3: You will receive a confirmation of your patients' appointment status or if we were unable to reach the patient.

YOUR INFORMATION

Referring Provider: _____ NPI Number: _____

Contact Name: _____ Phone #: _____

VISIT INFORMATION (CHECK ONE IN EACH CATEGORY)

SPECIALTY REQUESTED
- ☐ Adult Joint Reconstructive
- ☐ Orthopaedic Spine
- ☐ Interventional Spine/Pain/PMR
- ☐ Sports Medicine
- ☐ Hand and Upper Extremity
- ☐ Foot and Ankle

AREA REQUESTED
- ☐ Flagstaff **(F)**
- ☐ Prescott Valley **(PV)**
- ☐ Lakeside/Show Low **(L)**

TIME REQUESTED
- ☐ <48 hours
- ☐ First Available
- ☐ Less Than One Week
- ☐ Patient's Convenience

VISIT TYPE
- ☐ New
- ☐ Follow-Up
- ☐ EMG
- ☐ Workers' Comp
- ☐ Liability
- ☐ Date of Injury: _____

PROVIDERS AND LOCATIONS

- ☐ Bourck Cashmore,MD **(F, PV)**
- ☐ Fady Hijji, MD **(F, PV)**
- ☐ Yuri Lewicky, MD **(F, PV)**
- ☐ Eamonn Mahoney, MD **(F, PV, L)**
- ☐ Mark Mellinger , MD **(F, PV, L)**
- ☐ Kael Nahikian, MD **(F, PV)**
- ☐ Blake Obrock, DO **(F, PV)**
- ☐ Hayden Poulson, DPM **(F, PV)**
- ☐ Ryan Zate, DO **(F, PV)**

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Phone: (H) _____ (Cell) _____ (Work) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Guardian Name (if applicable): _____ DOB: _____

Reason for Visit/Diagnosis:

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Primary Ins. Address _____ Or P.O. Box: _____

Secondary Insurance: _____ ID #: _____

Cardholder's Name: _____ DOB: _____

Please refer to the insurance guide to determine if the patient requires a referral; if a referral is required, please note we will need to receive the referral from your office prior to seeing the patient.

When sending the referral, please include the approved number of visits and valid date range (i.e. 90 days)

northAZortho.com

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REFERRAL CHECKLIST

When sending referrals:

To better serve our patients and our referring offices, we have put together a checklist of items needed to successfully process your patient's referral.

Please use the list to the side and confirm your patient's referrals include the following information.

- ☑ Name of Patient
- ☑ Date of Birth
- ☑ Patient's Contact Number
- ☑ Valid Dates or Range
  - Ex: Referral good for 3 months, 6 months, etc.
- ☑ Number of Authorized Visits
  - Ex: Eval and treat = 2 visits
  - Ex: Eval and treat, 6 visits = 1 eval & 5 office visits
- ☑ Body Part and /or Diagnosis
- ☑ Specialty
- ☑ Correct Insurance Information and Insurance Address *
- ☑ Referring Provider Information
- ☑ Primary Care Provider (if different than Referring Provider)

*** NOTE: If possible, it would be helpful if you could also send a photocopy of the front of the patient's Insurance Card**

PLEASE BE AWARE: IF THE PATIENTS INSURANCE REQUIRES A REFERRAL, WE MUST RECEIVE THE REFERRAL FROM YOUR OFFICE PRIOR TO THE PATIENTS SCHEDULED APPOINTMENT IN ORDER TO BE SEEN.