Washington Pacific Eye Associates
134 Central Way
Kirkland, WA 98033
P: 425-889-2020
F: 425-739-0601

REFERRAL REQUEST FORM

Thank you for your interest in referring a patient to our practice. Please provide a Referral or sign and return this form for our records.

REQUESTED SERVICES:

☐ Evaluate and Treat ☐ Second Opinion: Patient will be returned to Referring Provider

☐ Co-Management ☐ Other: ______________________________

☐ Urgent ☐ Routine ______________________________

PATIENT INFORMATION

Patient Name: ______________________________

Patient Phone Number: ____________________ Email: ____________________

DOB: ____________________ SSN: ____________________

DIAGNOSIS / REASON FOR REFERRAL: ______________________________

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INSURANCE INFORMATION

Vision Insurance Name: ____________________ ID/Member #: ____________

Primary Medical Insurance Name: ____________________ ID/Member#: ____________

Secondary Insurance Name: ____________________ ID/Member #: ____________

Subscriber Name: ☐ Patient ☐ Other: ______________________________

REFERRING PROVIDER INFORMATION

Name of PCP/Referring Provider: ______________________________

Contact Phone: ____________________ **NPI**: ____________________

# of visits authorized: __________ **Date Range**: ____________________ **OR** ☐ OPEN REFERRAL

Signature of PCP/Referring Provider: ______________________________ **Date**: ____________

PLEASE FAX COMPLETED FORM TO: 425-739-0601