

Mercy Family Medicine
Referral/Precertification Request

Patients: If you are requesting a referral please print and fill out the top half of this form and fax to (314) 995-4127.

Name: _____ Date of Birth _____
Home Phone : _____ Work Phone _____
Primary Insurance: _____
Secondary Insurance: _____
Specialist Requested : _____
Test Requested: _____
Diagnosis/Reason for referral: _____
Physician you usually see: _____
Primary Care Physician Listed On Card: _____

Patients: Do Not Write Below This Line!

This information will be called to the patient.

Date Requested: _____	Number of Visits: _____
Date Received: _____	Referral Number: _____
Physician approval/signature: _____	Expires On: _____
Completed By: _____	
Date Completed: _____	Date called to patient: _____
	Date called to specialist: _____
Date test/referral visit scheduled: _____	

It is the patient's responsibility to inform the specialist of the referral number unless otherwise requested.

All referrals require at least one week to process unless deemed urgent by the patient's physician. Same day referral requests will not be granted for non-urgent referrals, it is the patient's responsibility to be aware of the referral requirements of their insurance plan.