

# PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

6355 Walker Lane • Suite 401 • Alexandria, Virginia 22310 • 703-924-2100 • Fax 703-922-6067

## REFERRAL REQUEST FORM

Please allow 3-5 business days for all referrals to be processed. Before scheduling an appointment with a specialist you must confirm that it is a participating provider with your insurance company.

Out-of-network referrals will not be processed for specialist visits.

When scheduling your child's follow-up appointment ask the specialist office if you will be needing a new referral for their next scheduled visit.

**\*\*\*BACK DATED REFERRALS WILL NOT BE CREATED\*\*\***

### Parent/Guardian

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First

Insurance Co. \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Specialist Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Tel.# \_\_\_\_\_

Reason for Visit (Diagnosis): \_\_\_\_\_  Initial Visit  Follow-up Visit

Once the referral is completed it can be:  Picked up or  Mailed

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

**\*\*Referrals will no longer be faxed; specialist offices are requesting original hard copy of referrals to be brought to appointments.**