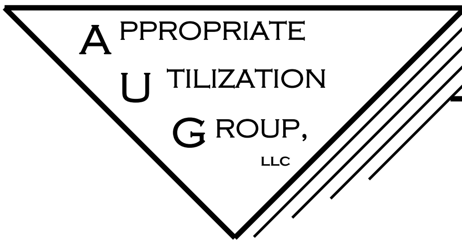

881 Piedmont Avenue Atlanta, GA 30309
(404) 728-1974 FAX (404) 728-1975
E-Mail: aug@augreviews.com

REFERRAL FORM

1. REFERRING COMPANY:

CUSTOMER: ____________________

ADDRESS: ____________________

CITY/STATE/ZIP: ____________________

CONTACT: ____________________

PHONE #: ____________________

FAX #: ____________________

E-MAIL: ____________________

2. CLAIMANT/PATIENT INFORMATION:

Claim #: ____________________

Patient Name: ____________________

Patient SS #: ____________________

Diagnosis: ____________________

3. PROVIDER INFORMATION:

Provider: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone #: ____________________

FAX #: ____________________

☐ Physical Therapist
☐ Other: ____________________

4. CLAIM TYPE:

☐ WC ☐ PI ☐ MP ☐ AL ☐ GL ☐ GH

Date of Injury: ____________________

Date Treatment Began: ____________________

Has Patient been discharged? Yes ☐ No ☐

Time Lost (WC Only)? Yes ☐ No ☐

Turnaround Time:
☐ Expedited (2-3 days) extra charges apply
☐ Standard (5-7 days)

5. Type of Review

☐ Pre-Authorization/prospective Review
☐ concurrent management
☐ retrospective
☐ Appeal

Special Request:

I hereby grant authorization to AUG to review all necessary medical information regarding this file.

____
Customer Representative **Date**

6. FOR AUG USE ONLY:

AUG Case # ____________________

Date Received ____________________

Reviewer: ____________________

Other: ____________________

Entered -

Invoiced -

Invoice # -