



INGHAM REGIONAL GYN ONCOLOGY

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Phone: (517) 975-9875 Fax: (517) 975-9897

Patient # _____

Date: _____

Referring Physician Name: _____

Referring Physician Location/Practice Name: _____

Address: _____

Phone: _____

Referring Physician ID#: _____ NPI # _____ License # _____

UPIN# _____ PHP# _____ BCS _____ Medicaid # _____

Referral required? Yes / / No / / If yes, referral authorization # _____

Patient's Name: _____

Reason for Referral (Dx) : _____

Patient's SSN: _____ DOB: _____

Patient's Address: _____

Patient's Phone # Home: _____

Work: _____

Cell: _____

Other: _____

Insured's Name: _____ DOB: _____

Relationship to Patient: _____

Insurance Co Name: _____

Insurance Contract # _____ Group # _____

Date/Time of Appointment: _____

NOTE: Please include any pertinent information with Referral Form; i.e., labs, office notes, pathology reports, etc.

For IRGO Office Use Only: Received Pt records: / / Mailed Pt map & info packet: / /

Insurance Verified: / / Coverage: _____

Deductible: _____ Co-Pay: _____

NOTES: _____