



newpatientcoordinator@clearwaypain.com (Preferred Method of Communication)

Phone Number: (850) 484-4080 Option 1

Fax Number: (833) 810-1165

NEW PATIENT PAPERWORK IS AVAILABLE AT WWW.CLEARWAYPAIN.COM

PROVIDER

- First Available Option
 - Pain Management
 - Chiropractic
- Requested Provider: _____

PLEASE INCLUDE

- Last Office Note
- Radiology Reports
- Previous Pain Management Records (if applicable)
- Copy of Authorization
- Copy of Insurance Card
- Copy of Driver's License

HELPFUL INFORMATION

- Referrals are valid for 90 days
- We make at least 3 attempts to contact before suspending efforts
- Providing all requested information at the time of submission greatly reduces the amount of time it takes to schedule
- All referrals are contacted within 3 business days

NEW PATIENT REFERRAL SUBMISSION FORM

Date: _____ Contact Person: _____
 Referring Doctor: _____
 Phone: (_____) _____ Fax: (_____) _____
 E-Mail: _____

PATIENT INFORMATION

Name: _____
 DOB: _____ SSN: _____ Gender M F
 Phone: (_____) _____ Alternate Phone: (_____) _____
 E-Mail: _____
 Address: _____

 Diagnosis Code and Description: _____

IF WORKER'S COMP OR MVA

DOI/DOA: _____ Adjuster Name: _____
 Adjuster Phone: (_____) _____

INSURANCE INFORMATION

Carrier: _____ PPO HMO
 Subscriber Number: _____ Group Number: _____