Mario Bustamante, MD PA
12770 Cimarron Path, Suite 132, San Antonio, TX. 78249
Tel: (210) 614-3900 Fax: (210) 614-7270

PROVIDER REFERAL FORM

Referring Physician Information

Date: _____

Physician Name:_____ NPI: _____

Clinic Name/ Address: _____

Office Contact Name: _____Phone #: _____

Fax # : _____ E-Mail :_____

Patient Information

Patient Name: _____ DOB:_____

Address: _____

City:_____ State: _____ ZIP: _____

Phone #: _____ Work #:_____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #_____

Authorization Number: _____ Visit #: _____

W/C Insurance: _____ DOI #: _____

Adjuster: _____ Phone #: _____

Claim #: _____ Compensable Body Part: _____

Appointment Information

[ ] Hand/ Wrist [ ]Hip/ Pelvic [ ] Foot/ Ankle [ ] Cervical/ Lumbar

[ ] Elbow [ ] Shoulder [ ] Knee [ ] Other_____

Diagnosis/ICD-10_____

Referral Service requested (check all that apply)

[ ] General Orthopedic Consultation [ ] Surgical Consultation [ ] I A Injections

[ ] ESI [ ] Other _____

*Any HMO Insurance will require authorization for X-Rays *

Please have patient bring CD/Films of X-Rays / MRI to appointment if available