MIAMI REHAB LLC

PATIENT REFERRAL FORM
Referrals@MiamiRehabLLC.com

Patient's Last Name:_____**First Name**_____

Date of Illness or Injury:_____ **Surgery date:**_____

Social Security Number_____

Permanent Street Address:_____

City_____ **State**_____ **Zip**_____

Phone#_____

Cellular#_____**Work#**_____

Physician Name_____ **Physician Phone Number**_____

Insurance Company Name_____

Insurance Street Address _____ **City**_____ **State** _____

Zip_____

Case Manager:_____**Phone:** _____

Fax:_____**Email:**_____

Adjuster:_____**Phone:**_____

Fax:_____**Email:**_____

Number of visits authorized:_____**Authorization/Claim#**_____

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Brief description of Patient complaint, injury, or illness, reason for treatment and referral:

_____
_____
_____
_____
_____

MIAMI REHAB LLC • P.O. BOX 961355 • MIAMI, FL 33296
OFFICE: 786-227-6843 • 1-888-960-9704 • FAX: 786-227-6708 • 1-888-960-9705