

**REFERRAL REQUEST**

**Spruce Street Internal Medicine, LLC**  
**2575 Spruce Street, Boulder Co 80302**  
**Phone: 303-449-3594 Fax:303-449-3112**

Request Date: \_\_\_\_\_ Appointment Date (if already made): \_\_\_\_\_

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Insurance Group# \_\_\_\_\_

Your PCP:	H Browne	A Miaocco	S Ling	L. Erben	K Johnson
Auth:	H Browne	A Miaocco	S Ling	L. Erben	K Johnson

Referred to: \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Phone \_\_\_\_\_

**Procedure:**            Consult                                    Testing                                    Evaluate & Treat

\_\_\_\_\_ With / Without Contrast (if applicable)

CPT Codes: \_\_\_\_\_

Reasons: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

\_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

\_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Approved: YES    NO

Auth # \_\_\_\_\_ # of visits \_\_\_\_\_ Start Date: \_\_\_\_\_ Exp: \_\_\_\_\_

If you need this referral to be faxed to your specialist,  
please provide their fax number here:

\_\_\_\_\_

**Please allow 72 hours for your referral to be processed. You will be notified when your referral is approved or denied.**