Lovelace Health System
Physician Referral Questionnaire

General Physician Information:

Provider Name: _____ _____ _____ _____
First MI Last (Jr./Sr.)

Phonetic Spelling: (If Necessary) _____

Title: ☐ M.D. ☐ D.O. ☐ D.D.S. ☐ Ph.D. ☐ Other _____

Email: _____

Gender: (__) Male (__) Female

In what year did you begin practicing? _____ Since what year have you resided in this area? _____

Formal Education:

	Institution Name	Year Grad.
Medical Degree:		
Internship(s):		
Residency(ies):		
Fellowship(s):		

Specialty(ies):

Specialty	Board Certified? Y/N	Accept referrals for this specialty? Y/N

If there are any situations where you would NOT like to receive a referral, please indicate below:

_____

_____

_____

_____

LOVELACE HealthLink

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Areas of Interest

If there are any special areas of expertise in which you are credentialed or have received additional training, please indicate below:

_____

If there is any personal information that you would like referral candidates to know about you, such as hobbies or interests, please indicate below:

_____

_____

Affiliations:

- ☐ Lovelace Medical Center
- ☐ Heart Hospital of New Mexico @ Lovelace Medical Center
- ☐ Lovelace Women's Hospital
- ☐ Lovelace Westside Hospital
- ☐ Lovelace Rehabilitation Hospital

Payment/Insurance Categories:

Please mark below (with an 'X') those payment/Insurance categories you accept or participate in:

General:

☐ Medicare ☐ Medicaid

Specific Insurance Information:

(___)	CHA	TRICARE/CHAMPUS
(___)	EPO	COVENTRY/FIRST HEALTH/CCN
(___)	HMO	BLUE CROSS BLUE SHIELD
(___)	HMO	COVENTRY/FIRST HEALTH/CCN
(___)	HMO	LOVELACE HLTH PLAN/LOVELACE INS CO
(___)	IND	BEECH STREET
(___)	IND	COVENTRY/FIRST HEALTH/CCN
(___)	IND	MULTIPLAN
(___)	IND	PRIVATE HEALTHCARE SYSTEMS
(___)	MCD	AMERIGROUP COMMUNITY CARE
(___)	MCD	BLUE SALUD/SCI
(___)	MCD	EVERCARE/UNITED HEALTHCARE
(___)	MCD	LOVELACE SALUD/SCI
(___)	MCD	MOLINA SALUD/SCI
(___)	MCD	NEW MEXICO ACS/FFS
(___)	MCR	LOVELACE SENIOR PLAN
(___)	MCR	MOLINA MEDICARE
(___)	POS	BEECH STREET
(___)	POS	CIGNA
(___)	POS	COVENTRY/FIRST HEALTH/CCN
(___)	POS	MULTIPLAN
(___)	POS	PRIVATE HEALTHCARE SYSTEMS
(___)	PPO	BEECH STREET
(___)	PPO	BLUE CROSS BLUE SHIELD
(___)	PPO	CIGNA
(___)	PPO	COVENTRY/FIRST HEALTH/CCN
(___)	PPO	HEALTHSMART
(___)	PPO	LOVELACE HLTH PLAN/LOVELACE INS CO
(___)	PPO	MULTIPLAN
(___)	PPO	PRIVATE HEALTHCARE SYSTEMS
(___)	WC	CORVEL
(___)	WC	NM MUTUAL

Payments Types

Credit Cards: [____]MC [____]Visa [____]Discover [____]Am Ex

Direct Payment: [____]Cash [____]Check

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Office Information: ☐ Primary Office

Name of Practice: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Closest cross streets: _____

Voice Phone Number:(_____) _____ - _____ Fax Phone Number: (_____) _____ - _____

What days/hours will someone be at this office to assist with scheduling?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

Please indicate with a check whether or not you generally see patients during the time frames indicated below.

Note: Specific appointment time availability will be determined at the time the referral is made.

Weekdays: [____] Evenings: [_____] Saturdays: [_____] Sundays: [_____]

What is the average waiting period (in days) for scheduling an acute care appointment? _____

Is this location Handicap accessible (Y/N)?

Is public transportation available to this location (Y/N)?

What foreign languages, if any, are spoken at this location?

(__) Yes, my practice has a Website that I want to link to the Physician Referral service.
*The website address is*_____

Additional office information you would like the referral candidate to know about, not provided elsewhere in this questionnaire.

_____

_____

Physician Signature _____ Date _____

Please email the completed form back to Libby at elisabeth.johnson@lovelace.com.
If you have any questions regarding the HealthLink program,
you may call 505.727.5501. Thank You!

LOVELACE HealthLink