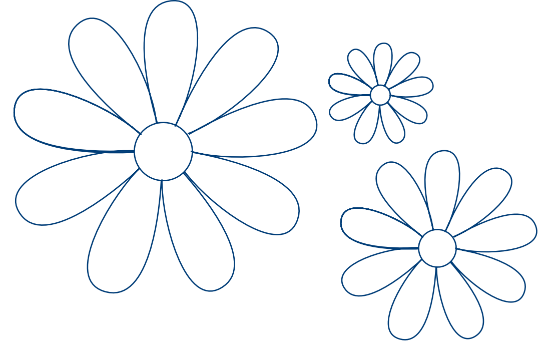
Referral Form
General Surgery



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**PLEASE FAX REFERRAL FORM,
PATIENT DEMOGRAPHICS AND INSURANCE CARD(S)**

Patient name: ______________________________ DOB: ____________________

Home phone: ______________________ Cell phone: ______________________

Insurance: ____

Referring provider office name: __________________ Referring provider office phone: ____________

Primary care provider name (if different from referring): ________________ PCP office phone: ____________

Reason for referral: ____

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Relevant labs and/or radiologic findings: ______________________________

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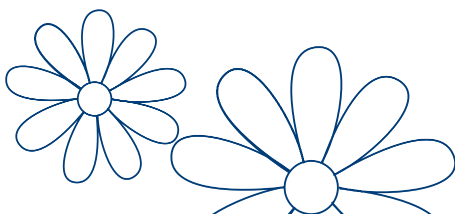
We accept most major insurance plans, including Blue Cross and Blue Shield of New Mexico, Molina, TRICARE, Medicare, Medicaid, UnitedHealthcare Community Plan, New Mexico Health Connections, True Health New Mexico and United Retiree Health Care Authority and many others.



Lovelace
Medical Group

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