**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:

**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/CC
(\_\_\_) IND BEECH STREET
(\_\_\_) IND COVENTRY/FIRST HEALTH/CCN
(\_\_\_) IND MULTIPLAN
(\_\_\_) IND PRIVATE HEALTHCARE SYSTEMS
(\_\_\_) MCD AMERIGROUP COMMUNITY CARE
(\_\_\_) MCD BLUE CROSS CENTENNIAL CARE/SCI
(\_\_\_) MCD EVERCARE/UNITED HEALTHCARE
(\_\_\_) MCD MOLINA CENTENNIAL CARE/SCI
(\_\_\_) MCD NEW MEXICO ACS/FFS
(\_\_\_) MCR LOVELACE MEDICARE PLAN (admin by BCBS)
(\_\_\_) MCR MOLINA MEDICARE

(\_\_\_) MCR HUMANA

(\_\_\_) 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 MULTIPLAN
(\_\_\_) PPO PRIVATE HEALTHCARE SYSTEMS
(\_\_\_) WC CORVEL
(\_\_\_) WC NM MUTUAL

(\_\_\_) MCR UNITED

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payments Types**

Credit Cards:[\_\_\_\_]MC [\_\_\_\_]Visa [\_\_\_\_]Discover [\_\_\_\_]Am Ex

 Direct Payment: [\_\_\_\_]Cash [\_\_\_\_]Check

**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 fax the completed form back to Raschel Brennan at 505.727.5720 or email raschel.brennan@lovelace.com.

If you have any questions regarding the HealthLink program,

you may call 505.727.5703. Thank You!