EMORY HEALTHCARE

DTC Generic Order

FAX orders to: 404.501.5703
Phone: 404.501.5580

Patient Information (Required for Scheduling)

Patient Name: ______________________________________ DOB: ____________________ Sex: ❑ M ❑ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: ____ ____________________ ______ __________
Street City State Zip Code

Home Phone #: ___________________ Mobile Phone #: ___________________ Email Address: _________________________________

Primary Insurance: __________________________ Policy #: _____________ Group #: _________ Insurance Phone #: _______________
Plan & Product

Secondary Insurance: ________________________Policy #: _____________ Group #: _________ Insurance Phone #: _______________
Plan & Product

Order Information

Diagnosis: ____

ICD CM Codes: ____

Test/Service: ____

CPT Codes: ____

Physicians orders: ☐ **Recurring account: expires**____________

Referring Physician Information

Physician Name (first & last): _____________________________________ NPI#: ________________ GA License #: _________________

Physician Address: ____ Phone #: ___________________ Fax #: __________________

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: ____ **Date:** ____________________ **Time:** __________________