GI Endoscopy Direct Access Referral Form

Date of Referral:	**Primary Insurance:**
Patient Information	
Name: (Last, First, MI)	
Address:	
Language: / **Phone:** ( )	
Date of Birth: (MM/DD/YY) ( )	**Secondary Insurance:**
Member Number: / **JHH History #:**	
Site Number:	
Primary or Requesting Provider	
Name: (Last, First, MI)	**Specialty:**
Institution/Group Name:	**Provider ID #1:**
Address: (Street #, City, State, Zip)	**Provider ID #2:**
	Phone Number: ( )
	Fax/Data Number: ( )
Consultant/Facility Provider	
Name: (Last, First, MI) **Johns Hopkins Direct Access**	Specialty: **GI**
Institution/Group Name: **Johns Hopkins Hospital**	
Address: (Street #, City, State, Zip) **1800 N. Orleans Street** **Baltimore MD 21287**	Phone Number: **(410) 502-0793**
	Fax/Data Number: **(443) 287-3847**
Referral Information:	
Procedure Requested:	
Reason for Referral: *(Outside referrals, please attach last H&P, lab work, and EKG if available)*	
Signature: (Individual Completing This Form)	**Authorizing Signature:** (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.