Referral to Dr. Subroto Kundu, East TN Neurology LLC

Referral From:_____NPI:_____MD/NP/PA/DO

Patient Name:_____ DOB: _____ Social: _____

☐ Consultation & Treatment ☐ Other: _____

☐EEG ☐EMG/NCV Upper Extremities ☐ EMG/NCV Lower Extremities

☐ Cleveland Office
3555 Keith Street, Suite 211
Cleveland, TN 37312
Phone: 423-790-1529
Fax: 423-790-1589

☐ Chattanooga Office
1720 Gunbarrel Road, Suite 306
Chattanooga, TN 37421-3192
Phone: 423-760-8989
Fax: 423-790-1589

Patient Phones:_____ Alternate:_____M ☐ F ☐

Pt Address: _____

Insurance**:_____ ID:_____ Group:_____

Worker's Compensation Patient? YES ☐ NO ☐

Insurance PCP Referral Required (Y/N): _____No. of Visits Allowed: _____

Ins. Auth No.: _____Start Date:_____End Date:_____

Policyholder: ☐Patient ☐ Other, please complete below for primary insured

Policyholder Name, Social and DOB:_____

Diagnosis or Reason Referred:_____

Today's DATE: _____ **Your Name:**_____

Referring Clinic:_____ Phone:_____ Fax:_____

Practice Address:_____

** **For WORKERS-COMP patients please have adjuster contact office for Acceptance Contract**
**** Is this an auto accident injury? Y or N if Y Patient will have to pay upfront**

Is there anything special we need to know?

PLEASE FAX PATIENT INFO, INSUARANCE CARD & PROGRESS NOTES
WE ACCEPT MOST INSURANCES including TENNCARE, BLUECARE, UHC & HEALTHSPRING