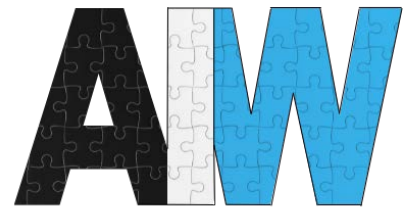


Referral Form



1. PATIENT INFORMATION		INSURANCE INFORMATION	
Date of Referral		Carrier Name (check one)	
Name (Last, First, MI)		United Healthcare	Cigna
Date of Birth		BlueCross BlueShield/Anthem	Aetna
Phone #	Site #	Other: please fill in below	
ID #			

3. PRIMARY OR REQUESTING PROVIDER		
Name (Last, First, MI)		Specialty
Institution/Group Name	Individual NPI	Group NPI
Address (Street, City, State, Zip)		
Phone #	Facsimile/Data #	

4. CONSULTANT/FACILITY PROVIDER		
Practice Name Aspire Integrative Wellness		Specialty NUTRITION/MENTAL HEALTH
Aspire Nutrition, LLP		Group NPI 1093315244
Address (Street, City, State, Zip) 1341 Canton Road, Suite B, Marietta, GA 30066		
Phone # 980-296-0044	Fax # 678-742-8047	

5. REFERRAL INFORMATION
Reason for Referral
Brief History, Diagnosis and Test Results

6. SERVICE DESIRED (PROVIDE CARE AS INDICATED)		ADDITIONAL INFORMATION
Initial Consultation Only _____ Nutrition Services _____ Testing Services (GI, Deficiency, Wellness) _____ Mental Health Counseling _____ Eating Disorder Treatment _____ Other (explain) _____		_____
Number of Visits Recommended	Authorization # (If required)	Referral is Valid Until (Date) *(See carrier instructions)
Signature (individual completing this form)		Authorizing Signature (if required)