Referral Form

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

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)