GRU GEORGIA REGENTS UNIVERSITY | COLLEGE of ALLIED HEALTH SCIENCES

Clinic for Prosthetic Restoration

Referral Form

Please complete and return to the mailing address below.

Patient Information

Name: _____ **Date of Birth:** _____

Address: _____

Phone: _____ _____ **Email:** _____

Insurance ID or SS#: _____

Prosthesis Need Information

Diagnosis or Necessitating Condition: _____

ICD-9/ICD-10 Code: _____

Prosthesis Type: _____

Method of Retention: _____

Prescription Applies: ☐ For a Lifetime ☐ From _____ To _____

Expected Replacement Frequency: _____ ☐ Per Physician Request ☐ Based on Patient Condition

Physician Making the Referral

Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

National Provider Identification #: _____ **Unique Physician Identification #:** _____

Physician Medicaid Provider #: _____

Statement of Medical Necessity: *I certify the medical necessity of the above-mentioned prosthesis for this patient. This form has been completed or reviewed by me, and has been signed by my own hand.*

Physician's Signature: _____ **Date:** _____

GRU Clinic for Prosthetic Restoration
Director / Anaplastologist: Amanda Y. Behr, CMI, CCA
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