Referral Source Verification Document

Instructions: Complete this form to verify the authenticity and details of the referral source. Print the completed document for the patient's physical record.

Patient Information

Patient Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Medical Record / Account Number: _____

Referral Source Information

Referring Provider Name: _____

National Provider Identifier (NPI): _____

Practice / Facility Name: _____

Phone Number: _____

Fax Number: _____

Verification Details

Date of Verification (MM/DD/YYYY): _____

Person Verifying Referral: _____

Verification Method (e.g., Phone, Fax, Portal): _____

Contact Person at Referral Source: _____

Referral & Authorization Specifications

Referral / Authorization Number: _____

Approved Diagnosis Code(s): _____

Authorized Services / Procedure Codes: _____

Number of Visits Authorized: _____

Effective Date (MM/DD/YYYY): _____

Expiration Date (MM/DD/YYYY): _____

Verification Signature Block

By signing below, the verifier confirms that the referral source has been verified according to facility protocols.

Verifier Signature: _____

Date Signed (MM/DD/YYYY): _____