

THE UNIVERSITY OF TENNESSEE HEARING & SPEECH CENTER

CHILD HEARING SERVICES

545 SOUTH STADIUM HALL

KNOXVILLE, TN 37996-2500

TEL: 865-974-1788 FAX: 865-974-1539

BOOKKEEPER TEL: 865-974-4633

Patient's Name: _____ Birthdate _____ Sex _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home) (Work)

Parent/Spouse/Legal Guardian: _____

1. Purpose of Referral (Please check those that apply)

Aural habilitation -pre-lingual Eval _____ Aural habilitation - post lingual Eval _____
Auditory Processing Test _____ Pre/Post Cochlear implant Eval. _____
Aural habilitation therapy _____ Aural rehabilitation therapy _____

2. Pertinent Medical History and/or Diagnosis:

3. Please list name of Insurance Carrier: _____

Subscriber ID#: _____ Group #: _____

Does the insurance carrier require a pre-cert or authorization number? _____

If so, PLEASE FAX TO OUR OFFICE BEFORE THE APPT. DATE OR INCLUDE
HERE. Pre-cert or authorization # _____ number of visits _____
dates visits are valid _____.

If patient has BlueCare/TennCare Select, physician's provider number _____.

4. If applicable, list name and phone number of Primary Care Physician:

(Name) (Phone)

5. Additional Comments:

PLEASE include physician's UPIN AND NPI _____.

Referring Physician: _____ Phone: _____

(Please print or type)

Signature of Physician: _____ Date: _____

Address: _____

Revised 01/2007