

EMPLOYEE PATIENT REFERRAL FORM

Date:

**Employee's
Name:**

**Office
Location:**

**Patient's
Name:**

**Patient
Number:**

**Contract
Date:**

**Banding
Date:**

**Orthodontist/Office
Coordinator Authorization:**

Mail completed Employee Patient Referral Forms to:
OrthoSynetics
Attn: Patient Accounting
3850 North Causeway Boulevard, Suite 800
Metairie LA 70002

Referrals must be submitted to Patient Accounting, who will authorize all referrals and forward them to Human Resources for payment. **FAXED REFERRALS WILL NOT BE ACCEPTED.**
Certified mail is recommended so proof of delivery can be received.

For Patient Accounting Use Only:

Authorized by:

Date:

For Human Resources Use Only:

Paid by: File #

P/E: EE status: A L T