Atrium Health

Atrium Health Transplant Center, a facility of Carolinas Medical Center
1025 Morehead Medical Drive, Suite 600 | Charlotte, NC 28204
Phone: 704-355-6649 | Fax: 704-446-4870

Instructions: Please fax completed form along with copy of insurance card(s) and copies of patient's records. Upon receipt, we will notify you with the appointment date and time and will forward a new patient packet to the patient.

Date: _____ Clinical in Cerner: ☐ Yes ☐ No

Patient Information

Patient's name: _____ ☐ Male ☐ Female DOB: ____/____/____

Marital status: _____ Race: _____ SSN: _____-_____-_____

Address: _____
Street City State Zip

Email Address: _____

Home phone: (____) _____ Cell: (____) _____ Work: (____) _____

Emergency contact name: _____ Relationship to patient: _____

Home phone: (____)_____ Cell: (____) _____

Insurance Information

Primary Care Physician: _____ Phone number: (___) _____ Fax: (___) _____

Primary insurance: _____ Policy #: _____ Group #: _____ ☐ INS Verified

Subscriber (if not the patient): _____ DOB: ____/____/____ NPI:_____

Employer: _____ ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled

Practice Information

Referring provider: _____ Reason for referral: _____

Practice name: _____ Office contact: _____

Address: _____
Street City State Zip

Phone number: _____ Fax number: _____

What service are you requesting?

☐ Transplant referral
☐ Office visit only
☐ Office visit with FibroScan*
☐ FibroScan only (CPT Code 91200)*

Please send the following:

☐ Recent labs ☐ Copy of CT disk/pathology slides
☐ Recent office note
☐ Radiology imaging

* Referring office must obtain authorization for the FibroScan before appointment

- Send copy of insurance card
- Please provide NPI number and authorization for all Medicaid Plans
- NOTE: We do not participate with Absolute Total Care, BCBS Blue Choice Medicaid, BCBS Blue Value, Cigna HealthSpring, Magellan, SC Medicaid Plans (CHS PE OON), Selection Health of NC, UHC Com pass and WellCare Health Connection.

****Office Use Only****

Appointment date: _____ Time: _____ Provider name: _____

Center for Liver and Digestive Disease: Referral Form