MARVEL CLINIC
Ear, Nose and Throat

1821 N. Washington St.
Tullahoma, TN 37388
Phone: 931-455-2005
Fax: 931-455-4450

Referral information:

Referring Provider: _____ Fax: _____

Reason for referral/Diagnosis: _____

Contact Person: _____ Phone: _____

Specific Requests: _____

Is the patient aware that we will be calling them? _____

Check if you request notification of scheduled appointment date _____

Patient information:

Name: _____ DOB: _____ SSN: _____

Mailing address: _____

City, State, Zip: _____

Preferred Phone: _____ Other number: _____

Insurance Information:

Primary Insurance: _____ ID#: _____ Group#: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Subscriber DOB: _____ Subscriber SSN: _____

Attach the Following Information:

_____ Insurance Cards

_____ Ordering visit note

_____ Face Sheet/Demographics

_____ Treatment History Related to Diagnosis

_____ Current Up to Date Medication List, including supplements

_____ Advance Directive, if applicable

_____ Imaging Reports Related to Diagnosis

Scheduling Instructions:

Please fax this completed form with requested attached information to 931-455-4450. If this information is not attached, it could delay scheduling. Due to high patient volume, it may take our schedulers up to one week to contact your patient to schedule. We will attempt to contact the patient three times, if we are unable to reach them you will be faxed a notice regarding our failed attempts. If requested above, we will also send out a notice of the scheduled appointment date. Once your patient's visit is complete, you will be faxed a copy of the completed visit note to the fax number listed above.

If you have an Urgent Appointment Request, Please fax requested information and call and ask to speak to a nurse.