Premier Health

Physician Referral Questionnaire

If you ***do not wish to participate*** in the physician referral program, please see the instruction at the bottom of the last page.

Please check the box next to the hospital your practice has an affiliation with:

☐ *Miami Valley Hospital* ☐ Active ☐ Academic

☐ *Good Samaritan Hospital* ☐ Active ☐ Affiliate

☐ *Atrium Medical Center* ☐ Active ☐ Affiliate

☐ *Upper Valley Medical Center* ☐ Active ☐ Affiliate

☐ *Premier HealthNet*

☐ *Premier HealthSpecialist*

General Physician Information:

Name _____
First MI Last Jr./Sr.

Title ☐ MD ☐ DO ☐ PhD ☐ Other _____

Gender ☐ Male ☐ Female Birth Date _____

In what year did you begin practicing? _____

Do you accept Physician to Physician Referrals Only? Yes ☐ No ☐

Formal Education	**Institution Name**	**Year Graduated**
Medical degree		
Internship(s)		
Residency(ies)		
Fellowship(s)		

Areas of interest

What **CONDITIONS** do you treat in your daily practice (feel free to give details down to conditions, treatment, and procedure level).

Specialty(ies):	Board Certified	Accepting referrals
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No

Office Information (The following information is needed for each additional office. You may copy this sheet.)

Practice/Office Manager Contact _____

Group Practice Name _____

Address (line 1) _____

Address (line 2) _____

City _____ State _____ Zip _____

Closest cross streets _____

Is this your primary office locations? ☐ Yes ☐ No

Voice Phone Number (___) ____-_____ Office Fax Number (___) ____-_____

Physicians e-mail address _____

Office hours

	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*
From	_____	_____	_____	_____	_____	_____	_____
To	_____	_____	_____	_____	_____	_____	_____

Does your practice close for lunch, and what is the time? _____

What is the average waiting period (in days) for scheduling an acute care appointment? _____

Does this location have:

Public transportation? ☐ Yes ☐ No

Handicap access? ☐ Yes ☐ No

What is the average new patient fee for a patient's first visit to this location? _____

What languages are spoken at this location? _____

Insurance Participation Please check the insurance below that are accepted at your office(s)

☐ *Amerigroup MCD* ☐ *Medicaid* ☐ *Molina MCD*
☐ *CareSource* ☐ *Medicare* ☐ *Tricare-Champus CHA*
☐ *Champus* ☐ *Medicare Assignment* ☐ *Workers Compensation*
☐ *Commercial/Indemnity* ☐ *MediGold*

Aetna
☐ EPO ☐ HMO ☐ POS ☐ PPO

Anthem
☐ EPO ☐ HMO ☐ POS ☐ PPO ☐ Medicare

Beechstreet
☐ EPO ☐ HMO ☐ POS ☐ PPO

Butler Health Plan
☐ EPO ☐ POS ☐ PPO

CIGNA
☐ EPO ☐ HMO ☐ POS ☐ PPO

Direct Care America/Primary Health Services
☐ EPO ☐ HMO ☐ POS ☐ PPO

Emerald
☐ EPO ☐ POS ☐ PPO

First Health/Coventry Healthcare
☐ EPO ☐ POS ☐ PPO

Flora Health Network
☐ EPO ☐ POS ☐ PPO

Galaxy Health Network
☐ EPO ☐ POS ☐ PPO

Great West Healthcare
☐ EPO ☐ POS ☐ PPO

Health Span
☐ EPO ☐ POS ☐ PPO

Humana
☐ EPO ☐ HMO ☐ POS ☐ PPO

Interplan - Direct Care
☐ EPO ☐ POS ☐ PPO

Medical Mutual of Ohio
☐ EPO ☐ HMO ☐ POS ☐ PPO

Mt. Carmel
☐ EPO ☐ POS ☐ PPO

Mt. Carmel Beh Health
☐ EPO ☐ POS ☐ PPO

Nationwide Health Plans
☐ EPO ☐ POS ☐ PPO

Ohio Health Choice
☐ EPO ☐ HMO ☐ POS ☐ PPO

PHCS (Private Healthcare Systems)
☐ EPO ☐ POS ☐ PPO

Ryan White
☐ EPO ☐ HMO ☐ POS ☐ PPO

UHC (United Healthcare)
☐ EPO ☐ HMO ☐ MCR ☐ POS ☐ PPO

United Behavioral Health
☐ EPO ☐ HMO ☐ POS ☐ PPO

Value Options
☐ EPO ☐ HMO ☐ POS ☐ PPO

Wellborn Health Plan
☐ EPO ☐ POS ☐ PPO

Payment Types ☐ MC ☐ Visa ☐ Discover ☐ Am Ex ☐ Cash ☐ Check

☐ **NO**, I do not want to participate in the Physician Referral Service. Please complete your name on page one. Sign and date the lines below, and return this questionnaire to the address indicated on the cover letter to be removed from the Referral Roster.

☐ **YES**, I want to participate in the Physician Referral service. I authorize you to release any of the information enclosed in this questionnaire to members of the community who call the Physician Referral Service in need of healthcare services. Please fax back the completed questionnaire to **(937) 499-5240**.

☐ **Yes, I agree to have my likeness or image appear in the hospitals website under Find a Doctor.**

Physician Signature _____ Date _____