BENJAMIN LIESS MD FACS
ENT, ALLERGY, AND AUDIOLOGY, LLC
144 US Route 1, Scarborough, ME 04074
p. 207.415.4841 f. 888.612.5691

Date:_____

Patient Name: _____Middle Initial _____
Patient DOB: ____/___/_____
Patient Address: _____
_____
Home Ph:_____Cell Ph: _____Work Ph: _____

Referral From: Name of Patient's Primary Care Physician: _____
Address: _____
Phone# _____ Fax#_____
Primary Physician NPI# _____

Primary Insurance Company: _____
Subscriber Name: _____
Subscriber Member ID# _____
Group # _____

Secondary Insurance Company: _____
Subscriber Name: _____
Subscriber Member ID# _____
Group # _____

****IMPORTANT** PLEASE COMPLETE ALL OF BELOW INFORMATION***
*Date of ENT Referral: _____
*Reason For Referral: _____
*Referral Authorization Code: _____
*Maximum # of visits allowed: _____
*Referral Start Date: _____ *Referral Expiration Date: _____

Please include insurance referral if required and any clinical documents relating to the reason for this referral. Thank you for allowing us to provide quality ENT care to your patients.