Online Referral Form for Physicians

To refer a patient to a KCNMG physician or provider clinics, please complete the information requested below. **This is a secure form**, and the information you provide will enable us to assist your patient as efficiently as possible.

- ✓ Fax to 661.869.1834, Other Fax numbers can be found online at www.kernneuro.com
- ✓ Or just simply use the **SUBMIT/SEND** button to send it to us directly.
- ✓ Include brief pertinent medical records, including test results that support the consultation
- ✓ Include patients insurance card (both sides) and HMO authorization if required.

Referring Physician Office Information:

Referring Physician _____ Phone _____

Practice/Clinic Name _____

Contact Person: _____ Email _____

Address _____

City _____ State _____ ZIP _____

A KCNMG Referral representative will call the patient/contact person between 8:30am–5:00pm, Monday–Friday

Patient's Information:

Name _____ Birthday _____

If child, name of parent(s) _____

Phone _____ Cell _____

A KCNMG Referral representative will call the patient/contact person between 8:30am–5:00pm, Monday–Friday

Diagnosis _____

Preferred Provider _____ Visit Type: _____

Insurance:

Insurance Name: _____

Policy No. _____ (Primary) Subscriber _____ _____

Policy No. _____ (Secondary) Subscriber _____ _____

HMO Authorization: _____

Comment: _____

Include patient's insurance card (both sides) and HMO authorization if required.

- Faxed Medical Records and Insurance to 661.869.1834
- Emailed Medical Records and Insurance to kcnmg@kernneuro.com