



NOTE: Please take this form to the Student Health Programs Insurance Office for explanation of benefits prior to appointment with the specialist. This step must be followed.

Patient _____	Date _____
Complete I.D. # _____	
Date of Birth _____	
Medical Provider _____	

Place sticker here.

Referral is for:

- Diagnosis
- Follow-up
- Evaluation
- Other
- Treatment
- X-Rays
- Lab work being sent

Name/Specialty _____ Date _____ Time _____

Place _____

Diagnosis/Nature of Condition _____ Date of onset _____

Pertinent Clinical Data:

Please check if athletic

EXAMPLE

Date _____ Signed _____ MD

IMPORTANT: PLEASE SEND A COPY OF YOUR EVALUATION TO ME AT THE ADDRESS BELOW!!

I authorize my referring provider at SIUC to release information from my record deemed necessary for the appointment with my referral provider. My record information is to remain confidential and cannot be redisclosed without my consent. This consent is valid for one (1) year unless otherwise indicated, and may be revoked in writing at any time after my date of signing.

Date _____ Student Signature _____

THIS IS A REFERRAL ONLY. I understand that a referral is not a guarantee of payment. This Referral is only valid for one (1) year from original date of issue and is contingent upon enrollment. For details concerning benefits, refer to the Extended Medical Care Benefit Plan Brochure. Student insurance will be Excess if other insurance is available. For payment to be considered, a medical summary, itemized statement, claim form, and explanation of benefits from other insurance companies are required.

Date _____ Student Signature _____

Mailing Address: Student Health Programs, Student Medical Benefit Office, Mailcode 6802, Southern Illinois University, Carbondale, IL 62901

Date _____ Signed _____ Medical Insurance Specialist

Enrollment Verification: Current Semester _____ Fall 20 _____ Spring 20 _____ Sum 20 _____

BROCHURE GIVEN _____