

# PRS

## PHYSICIAN REFERRAL SERVICES

PHONE: 800.431.5151 OR 508.856.5656 | FAX: 508.334.7616

With over 120 years of combined UMMHC experience the PRS team is here to serve you. **We are here to help:**

- ✓ Schedule outpatient appointments
- ✓ Identify appropriate specialists for consultation
- ✓ Facilitate physician-to-physician communication
- ✓ Obtain medical records and lab results
- ✓ Provide information about specialized services

### GREETINGS FROM OUR TEAM TO YOURS!

2018 is in full swing and we're pleased to share a few updates to help strengthen our partnership with you. We're improving processes so we can schedule your patients as quickly and efficiently as possible. Thank you!



The PRS Team (L-R): Meghan, Lesley, Sheena, Kiki, Mirion and Denise.

“My practice greatly benefits from utilizing Physician Referral Services. They improve communication and expedite patient care. I highly recommend this team!”  
— Worcester Internal Medicine

### Scheduling a Mammogram?

For faster service please provide the following:

- When/Where was patient's last Mammogram?
- Does the patient have implants?
- Is there any history of cancer?
- Is the patient experiencing any type of issues? If yes — location?
- Is the patient breastfeeding?
- Can the patient sit or stand?



“You all rock at PRS and this is why we like to use your service. Thank you so much for everything!”

— Cornerstone Family Medicine

### Expediting Epic Requirements

Entering the following into our new intake form makes the referral process easy:

- Patient's Name, DOB, Sex, Address, Phone
- Race and Ethnicity
- Primary Insurance, Policy #, Guarantor
- Secondary Insurance, Policy #, Guarantor, Subscriber

**Epic** ONE PATIENT.  
ONE RECORD.  
ONE LOGIN.

 **UMassMemorial  
Health Care**

SEE REVERSE SIDE FOR OUR 2018 INTAKE FORM.



# UMassMemorial Health Care

Physician Referral Services - Intake Form

Telephone: 800-431-5151 / 508-856-5656 Fax: 508-334-7616 Date: \_\_\_\_\_

**INFORMATION BELOW IS REQUIRED FOR EPIC.**

PCP / Referring MD:

Phone:

Fax:

Contact Name:

Priority of Request: (check one below)

Urgent [24-48 hrs.]

**\*Medical Reason for Urgency**

**\*Requires clinical notes & recent imaging**

ASAP [7-10 days]

Non-Urgent [30 days]

2nd Opinion

Consult

Interpreter needed:            Y    N

Language:

Specialty Clinic:

Preferred Provider:

Preferred Location:

**\*\*Note: To expedite scheduling appointments, please make sure the following information is sent to PRS.**

- Complete and fax any clinical notes, labs, x-rays, MRI's, Cat Scans.
- Questionnaires for Mammography, Cat Scans, Nuclear Med must be filled out and faxed with referrals.

PATIENT:	
DOB:	SEX:
ADDRESS:	
EMAIL:	
PHONE: (H)	(C)
RACE:	
ETHNICITY:	
PRIMARY INSURANCE:	
POLICY NUMBER:	
GUARANTOR (NAME/DOB): (UNDER 18)	
SECONDARY INSURANCE:	
POLICY NUMBER:	
GUARANTOR (NAME/DOB): (UNDER 18)	
SUBSCRIBER (NAME/DOB):	

Diagnosis:	ICD 10 CODE:
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Prior Authorization:	Contact Name:
Dates:	Telephone:
Number of visits:	
*Required for MRI's and CT Scan's	

MVA / Worker's Comp:	Date of Injury:
Claim Number:	
Insurance Co:	Address:
	Telephone: