Sharon Hong, M.D. | Teresa Crout, M.D. | Jordan Smith, FNP-C

ATTN: REFERRALS DEPARTMENT

PLEASE REVIEW BEFORE SUBMITTING REFERRALS

Thank you for referring your patient to **Mississippi Rheumatology & Osteoporosis Center, PLLC.** We appreciate the confidence you have placed in our providers and staff. Our goal is to provide timely, compassionate, and comprehensive rheumatologic care while maintaining clear communication throughout the referral process.

To help us process referrals as efficiently as possible, complete the attached referral form and include all requested documentation, including:

- Referral order
- Pertinent office notes
- Relevant laboratory and imaging results
- Patient demographics
- Copies of the patient's insurance card(s)

Please fax all required documentation to **(601) 420-5482**. Incomplete referrals may delay processing and scheduling.

Once the referral has been received, insurance eligibility has been verified, and the provider has reviewed and approved the referral, our office will contact the patient directly to schedule an appointment. After the appointment has been scheduled, a fax confirmation with the appointment details will be sent to your office.

If you have any questions regarding a referral, please contact our office at **(601) 420-0034**.

Thank you again for your continued trust and partnership in the care of your patients.

2550 Flowood Drive, Suite 300
Flowood, MS 39232
Office: 601-420-0034
Fax: 601-420-5482
www.msrheumosteo.com

Patient Referral Form

Patient Information
Patient Name: _____ **Date of Birth:** ____ / ____ / _____
Street Address: _____
City: _____ **State:** _____ **ZIP:** _____ **Phone:** _____

Insurance Information
Primary Insurance: _____
Policy/Member ID: _____
Secondary Insurance: _____
Policy/Member ID: _____

Please Note: Mississippi Rheumatology & Osteoporosis Center does not participate with Medicare Advantage plans, Medicaid plans, or Marketplace (Exchange) insurance plans.

Referring Provider Information (must be completed)
Referring Provider: _____
Practice Name: _____
Phone: _____ **Fax:** _____
Address: _____
City: _____ **State:** _____ **ZIP:** _____

Referral Information
Reason for Referral / Diagnosis:
_____
_____
_____
_____

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