Please select the urgency
STAT
ASAP (1-2 weeks)
Within 1 month
First Available

Texas Tech Physicians

Referral Form

Name:	Date of Birth:
Phone Number:	Sex:
Address:	City/State/Zip
Guarantor Name:	Guarantor Date of Birth:
Primary Insurance:	Effective Date:
Subscriber Name and Date of Birth:	
Member ID:	Group Number:
Worker's Comp Claim Number	Date of Injury
Workers' Comp Name & Billing Address	
Adjuster Name, Phone, & Fax:	Adjuster Email:
Referral Reason:	Diagnosis:
Referring From (Clinic):	Referring From (Provider):
Referring Clinic Phone:	Referring Clinic Fax:
Referring to (Clinic):	Referring to (Provider):

Please fax this form, along with insurance cards, identification, and clinic notes to 806-743-4887.