

ORTHOPAEDIC ASSOCIATES OF MARLBOROUGH, P.C.
65 FREMONT STREET SUITE 1
MARLBOROUGH, MA 01752
508-485-3665

CONSULTATION DUAL DOCUMENTATION REQUEST FORM

Medicare guidelines for consultation services require the intent of the request to be clearly documented by the provider and specialist.

You are sending _____ D.O.B _____

to see Dr. _____ on _____ for _____ .
(MD requested to provide service)

***** THIS REQUEST WAS FOR :** (PLEASE SELECT ONE)

CONSULTATION

OR

TRANSFER OF CARE

Please select one of the above and fax back to 508-597-0116
prior to the appointment.

Thank you.