UF Congenital Heart Center
UNIVERSITY of FLORIDA

☐ **CHC Gainesville, FL**
Medical Plaza, 2nd Floor
1600 SE Archer Road
Gainesville, FL 32610-0296
Telephone: (352) 273-7770
Fax: (352) 392-0547

☐ **CHC Halifax, FL**
311 N. Clyde Morris Blvd, STE 100
Daytona Beach, FL 32114
Telephone: (386) 226-2662
Fax: (386) 226-2593
Referral Fax: (352) 627-4522

☐ **CHC Ocala, FL**
1500 SE 17th Street
Ocala, FL 34471
Telephone: (352) 273-7770
Fax: (352) 392-0547

PEDIATRIC CARDIOLOGY REFERRAL FORM

Date: _____

Patient Name (Last): _____ (First): _____ (MI): _____

Male or Female: _____ Date of Birth: _____ SS # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Alternate Phone: (_____)_____

Parent/Guardian: (Last, First) _____ Relationship to Patient: _____

Guarantor Name (If different than above): _____ Date of Birth: _____

Insurance Co: _____ Phone: _____

Policy #: _____ Group #: _____

Insured Name: (Last, First) _____ Insured DOB: _____

Auth: # _____ UHC Referral Online Submission # (if applicable) _____

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Referring MD: _____ Contact Person: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

PCP (If different than the Referring MD): _____ Phone: _____

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Diagnosis/Reason for Referral: _____
_____
_____
_____

Provider NPI: 1699874248 * Provider Tax ID: 591680273 * Facility Tax ID: 591943
Procedure Codes: New Patient: 99243, Echo: 93306, EKG: 93010, Tracing for EKG: 93005
Please include office notes with referral