Edwards Comprehensive Cancer Center

A provider based clinic of Cabell Huntington Hospital
1400 Hal Greer Blvd
Huntington, WV 25701
Fax 304-399-6593

Cabell Huntington Hospital
Member of Marshall Health Network

Is this referral urgent? ◯ **Yes** ◯ **No**

Please fill out this form completely, including any clinical documentation relevant to this referral, and fax all documentation to **(304)399-6593**

Missing information (including clinical documentation) may result in a processing delay.

◯ **Clinical Documentation included?** **(Insurance card Copies**, Medical Records, Lab and Pathology, X-Rays/Scans/Ultrasound)

PATIENT INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ Gender:_____ SS#_____ Primary Phone #_____

Street Address: _____ City _____

State:_____ Zip Code_____ Race: ____Caucasian ____African American _____Asian ____ Hispanic____ Other____

Ethnicity: _____Hispanic _____Non-Hispanic Is Language interpretation needed? ◯ Yes ◯ No

Patient Email:_____

Primary Insurance Carrier:_____

Secondary if applicable:_____

******* AUTHORIZATION / PRECERT NEEDED ON ANY PATIENT WITH THE FOLLOWING CARRIERS WE ARE NOT IN NETWORK WITH:**
(ANTHEM BLUE CROSS MEDICAID of KY, Buckeye Health Medicaid of Ohio, Anthem Medicare, Gateway Medicare HMO, Paramount Advantage Plan Ohio Medicaid HMO, KY Humana Caresource Medicaid, KY and OH Caresource Marketplace, Ohio United Healthcare Optimum Medicaid, Any Cards that have, Bronze, Silver or Gold)

Prior Auth#_____

Referring Provider_____ NPI#_____ Lic#_____ State_____

Street Address _____ City_____ State_____ Zip _____

Phone#_____ Fax# _____

Physicians Direct Messaging Address: _____

Primary Care Provider:_____

Reason for Referral:_____

_____

Diagnosis:_____ **ICD10:**_____

Please fill out this form and include any relevant clinical documentation and a copy of all insurance cards. Fax all documentation to **304-399-6593**. The Referral Clerk will coordinate with our staff to schedule your patient's appointment. Your office will be notified by phone or fax with the scheduled appointment date and time for you to contact the patient.

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PHYSICIAN REFERRAL

Please (Circle) which specialty, and if you are requesting a specific physician, please circle the Physician requested.
Fax this sheet along with the Referral Form to 304-399-6593

HEMATOLOGY/MEDICAL ONCOLOGY Phone 304-399-6500 fax 304-399-6593

- Maria Tirona, MD -Toni Pacioles, MD - Mina Shenouda, MD
- Muhammad Omer Jamil, MD

SUPPORTIVE CARE – Scott Mitchell, MD 304-399-6500 fax 304-399-6593

LUNG NODULE CLINIC – Yousef Shweihat, MD 304-399-6770 fax 304-399-6593

UROLOGY ONCOLOGY - James Jensen, MD Phone 304-399-6500 fax 304-399-6593

MUSCULOSKELETAL ONCOLOGY – Felix Cheung, MD Phone 304-399-6500 fax 304-399-6593

GYN ONCOLOGY – Nadim Bou Zgheib, MD (Please choose which site your patient prefers)

Edwards Comprehensive Cancer Center @ Cabell Huntington Hospital
1400 Hal Greer Blvd, Huntington, WV 25701
Phone 304-399-6500 fax 304-399-6593

ECCC Gyn Oncology @ Capital Neurology
414 Greenway Avenue, Suite 200, South Charleston, WV 25309
304-342-3891 fax records: 304-399-6593

FOR REFERRING OFFICE ONLY

Patient referred to: _____
Physician

Date:_____

Time:_____

Special Instructions:_____

_____