

Ryan P. O’Quinn, MD

Joshua L. Owen, MD, PhD

Courtney S. Aldridge, PA-C

Centralized Scheduling (210) 558-6234

Centralized Fax (210) 446-5039

**[ ] Ryan P. O’Quinn, MD [ ] Joshua L. Owen, MD, PhD [ ] Courtney Aldridge, PA-C**

**NPI: 1205881281 NPI: 1154717726 NPI: 1205966819**

**Group Tax ID: 47-0851901**

Centralized Scheduling: (210) 558-6234

Centralized Fax: (210) 446-5039

**Please FAX the Following:**

* **REFERRAL REQUEST FORM**
* **INSURANCE REFERRAL AUTHORIZATION**
* **PROGRESS NOTES**
* **PATH REPORT**
* **PATIENT DEMOGRAPHICS AND INSURANCE**

CLINIC LOCATIONS:

2632 Broadway, Suite 300 South

San Antonio, TX 78215

*(Consults, Office Visits & Mohs Procedures)*

9238 Floyd Curl, Suite 101

San Antonio, TX 78240

*(Consults, Office Visits & Mohs Procedures)*

813 Paris

Castroville, TX 78009

*(Consults, Office Visits & Mohs Procedures)*

**Common Referral Codes for Mohs: Referral Codes for Other Dermatology Visits:**

99203/99214 **PLUS** the Following CPT Codes: 99203/99214 **PLUS** 11102/11104 **AND** 17000

17311 and 17312 for **Head, Neck, Hands, Feet, Genitalia**

17313 and 17314 for **Trunk, Arms, Legs** **Common ICD-10 Dermatology Codes:**

**AND** Repair Codes: **Skin Lesion**- D48.5 **Rash**- L30.9 **Acne**- L70.9

Face: 13132, 13152, 14041, 14061, 15240, 15260 **Psoriasis**- L40.0 **Alopecia**- L65.9  **BCC**- C44.xxx

Trunk/extremities: 13101, 13121, 14021, 15220 **SCC**- C44.xxx **Melanoma**- C43.xxx **Melanoma In Situ**- D03.xxx



**Location**

**[ ] 2632 Broadway**

**Suite 300 South**

**San Antonio, TX 78215**

**[ ] 9238 Floyd Curl**

**Suite 101**

**San Antonio, TX 78240**

**[ ] 813 Paris**

**Castroville, TX 78009**

**Provider**

**[ ] First Available Physician**

**[ ] Ryan P. O’Quinn, MD**

**NPI: 1205881281**

**[ ] Joshua L. Owen, MD, PhD**

**NPI: 1154717726**

**[ ] Courtney Aldridge, PA-C**

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**Group Tax ID:**

**47-0851901**

**OFFICE (210) 558-6234**

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Please Fax Referral Request Form to (210) 446-5039

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Mobile Number: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Male [ ] Female

INSURANCE:

PRIMARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Subscriber SSN: \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

SECONDARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Subscriber SSN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician NPI#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Patient has been scheduled for:

DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Time: \_\_\_\_\_\_\_ AM / PM

[ ] Our Office has notified Patient of the appointment

Contact Person @ your office for this Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ CPT Codes: Evaluate & Treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD 10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization Number (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Visits Authorized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Expires: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

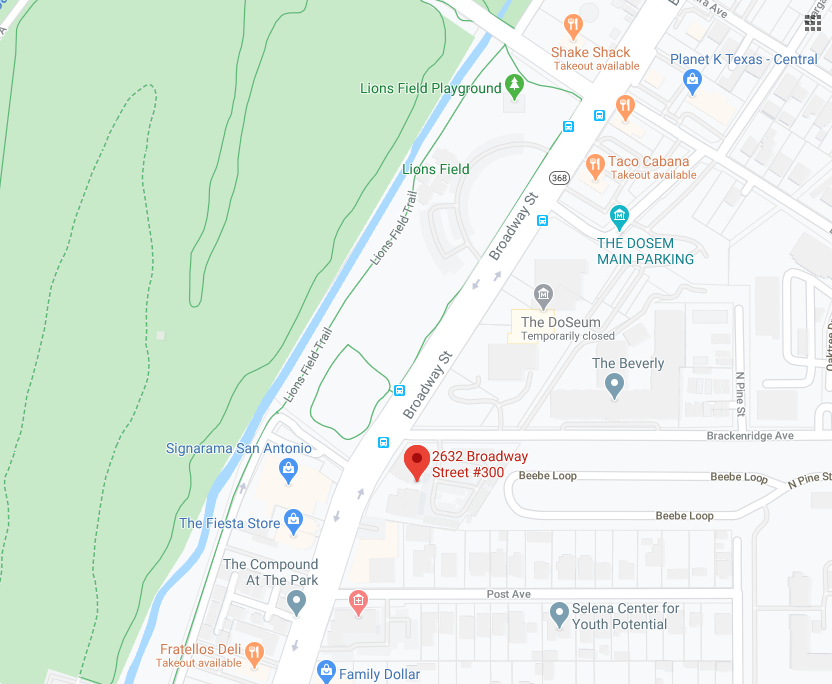
(PATIENT COPY)

Patient Instructions:

* **Please arrive 20 minutes prior to appointment time in order to finalize registration.**
* **A picture ID and your insurance card are required at the time of appointment registration.**
* **Copayment responsibilities are due at time of your registration.**

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***813 Paris, Castroville, TX 78009***



***CENTRALIZED APPOINTMENTS: (210) 558-6234***