505 S. Main St. Clifton, IL 60927
Phone: (800) 722-7313
Fax: (931)540-8209
referrals@ptmed.net

AAC Referral Form

This referral is for: ☐ New Device/Accessory ☐ Service/Repair of Existing Device/Accessory

Patient Information

Full Name: _____
Last *First* *Middle Initial*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Primary Contact: _____ **Relationship:** _____

Email: _____ **Phone:** _____

Primary Insurance: _____ **Secondary Insurance:** _____ ☐ **Katie Beckett**

*** Please attach copy of insurance card(s)*

Sex: ☐ Male ☐ Female **Date of Birth:** _____ **SSN:** _____

Primary ICD:10: _____ **Other ICD:10:** _____

SLP Name: _____ **Therapy Clinic:** _____

SLP Phone: _____ **SLP Email:** _____

Doctor Name: _____ **Doctor Clinic:** _____

Doctor Phone: _____ **Doctor Fax:** _____

Service/Repair Information

Type of Device: ☐ Nuvo ☐ Inspire ☐ Inspire XL **Type of Accessory:** ☐ Keyguard ☐ Switch ☐ Mount

Serial Number: _____ **Date Received:** _____ **Original Payor:** _____

Type of Repair: ☐ Screen Protector ☐ Screen ☐ Case ☐ Battery ☐ Software ☐ Accessory

☐ Other *(please specify)*:

Comments:

Please return via **FAX** (931) 540-8209 or **EMAIL** referrals@ptmed.net