



Stephanie S. Martin, M.D.

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REFERRAL FORM

Date: _____

Patient Information

Name: _____ DOB: _____

Address: _____

Phone: _____ Cell: _____

Referring Physician: _____

Referring Physician Phone: _____ Fax#: _____

Appointment Location: Atlanta Lawrenceville Villa Rica

Treating Body Part: Arm Ankle/Foot Back/Scoliosis Hand/Wrist Elbow Hip Knee Neck Shoulder

Side: Bilateral Left Right

Health Insurance: PPO POS MEDICAID (Kids only) Is a referral required? Yes or No

Insurance Carrier: _____ Policy #: _____

Special Instructions: _____

Please Fax:

1. Insurance Card
2. Patient Demographics
3. Any applicable medical records, including MRI copies
4. Or Email: aadams@performanceatl.com & manager@performanceatl.com

Please fax this referral form back to us at:

404-935-9832

**List of Participating Insurances
PPO, POS Open Access, and HMO Open Access Plans only**

Aetna, Amerigroup, Blue Cross Blue Shield, Cigna, Coventry, Humana, Medicaid (Kids only), Multiplan PPO/POS, Peach State (Orange Card), PHCS PPO, United Healthcare, Workers Compensation

****DOUBLE CHECK WITH YOUR INS CARRIERS FOR PARTICIPATION****

visit our website www.performanceatl.com