HackensackUMC Mountainside
Physician Referral Questionnaire

If you do *not* wish to participate in the physician referral program please see the instructions at the bottom of the last page.

General Physician Information:

Name: _____ _____ _____ _____
First MI Last (Jr./Sr.)

Title: (__) MD (__) DO (__) DDS (__) Ph.D. (__) Other: _____

Gender: (__) Male (__) Female Birth Date: _____/_____/_____

In what year did you begin practicing? _____ Since what year have you resided in this area? _____

Situations where you would NOT like to receive a referral _____

_____

_____

Personal information that you would like referral candidates to know about you, not provided for elsewhere in this questionnaire

_____

_____

_____

Formal Education:

	Institution Name	Year Grad.
Medical degree		
Internship(s):		
Residency(ies):		
Fellowship(s):		

Areas of Interest

Credentials/additional training/education that you would like referral candidates to know about (other than medical degree, internship, residency, and fellowship programs). _____

_____

_____

_____

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Specialty(ies):	Board Certified? Y/N	Accept referrals for this specialty? Y/N

Office Information: (The following information is needed for each additional office. You may copy this sheet.)

Group Practice Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Closest cross streets: _____

Is this your Primary office location (Y/N)? _____

Voice Phone Number: (_____) _____ - _____ Fax Phone Number: (_____) _____ - _____

Physicians e-mail address: _____

What time zone is in effect at this office (Eastern, Central, Mountain, Pacific, etc.) _____

Does this location honor Daylight Savings Time (Y/N)? _____

What days/hours will someone be at this office to assist with scheduling?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

Please indicate with a (Y/N) whether or not you generally see patients during the time frames indicated below.

Note: Specific appointment time availability will be determined at the time the referral is made.

Weekdays: [____] Evenings: [_____] Saturdays: [_____] Sundays: [_____]

What is the average waiting period (in days) for scheduling an acute care appointment? _____

Does this location have: Public transportation (Y/N) ?_____ Handicap access (Y/N) ? _____

What is the average new patient fee for a patient's first visit to this location? _____

What foreign languages, if any, are spoken at this location?

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Insurance Participation Please check the insurances below that are accepted at your office(s)

[____]Commercial / Indemnity [____]Medicare [____]Medicare Assignment

[____]Medicaid [____]Workers Comp [____]Champus

(___)	EPO	AARP
(___)	EPO	ADVANCED HEALTHCARE SYSTEMS
(___)	EPO	AIG
(___)	EPO	ALLSTATE
(___)	EPO	AMERICAN BANKERS INSURANCE GROUP
(___)	EPO	AMERICAN POSTAL WORKERS
(___)	EPO	ANTHEM HEALTH & LIFE
(___)	EPO	ATLANTIC HOME CARE AND HOSPICE
(___)	EPO	CORESOURCE
(___)	EPO	ETHIX
(___)	HMO	AARP
(___)	HMO	ADVANCED HEALTHCARE SYSTEMS
(___)	HMO	AETNA
(___)	HMO	AIG
(___)	HMO	ALLSTATE
(___)	HMO	AMERICAN BANKERS INSURANCE GROUP
(___)	HMO	AMERICAN POSTAL WORKERS
(___)	HMO	AMERIHEALTH
(___)	HMO	ANTHEM HEALTH & LIFE
(___)	HMO	ATLANTIC HOME CARE AND HOSPICE
(___)	HMO	CIGNA HEALTHCARE
(___)	HMO	CORESOURCE
(___)	HMO	ETHIX
(___)	HMO	HORIZON BCBSNJ
(___)	HMO	KEYSTONE HEALTH PLAN
(___)	HMO	MAGELLAN
(___)	HMO	PRUDENTIAL
(___)	HMO	QUALCARE
(___)	HMO	TIME FORTIS
(___)	HMO	WELLCHOICE EMPIRE HMO PPO POS
(___)	IND	AARP
(___)	IND	ADVANCED HEALTHCARE SYSTEMS
(___)	IND	AETNA
(___)	IND	AIG
(___)	IND	ALLSTATE
(___)	IND	AMERICAN BANKERS INSURANCE GROUP
(___)	IND	AMERICAN POSTAL WORKERS
(___)	IND	AMERIHEALTH
(___)	IND	ANTHEM HEALTH & LIFE
(___)	IND	ATLANTIC HOME CARE AND HOSPICE
(___)	IND	CIGNA HEALTHCARE
(___)	IND	CORESOURCE
(___)	IND	ETHIX
(___)	IND	FIRST TRENTON
(___)	IND	HORIZON BCBSNJ
(___)	IND	MMH EMPIRE BCBSNY
(___)	IND	PRUDENTIAL
(___)	IND	UNITED HEALTHCARE
(___)	IND	WELLCHOICE EMPIRE HMO PPO POS
(___)	MCD	MEDICAID DENTAL
(___)	MCD	MEDICAID HEALTHSTART
(___)	MCD	MEDICAID NJ
(___)	MCD	MEDICAID NY
(___)	MCD	MEDICAID OUT OF STATE
(___)	MCD	UNIVERSITY HEALTH PLAN MEDICAID
(___)	MCR	AETNA
(___)	MCR	AMERIHEALTH MANAGED MEDICARE
(___)	MCR	FIRST OPTION HEALTH PLAN
(___)	MCR	MEDICARE IME
(___)	MCR	OXFORD ADVANTAGE MEDICARE
(___)	MCR	UNITED HEALTHCARE
(___)	POS	AARP
(___)	POS	ADVANCED HEALTHCARE SYSTEMS
(___)	POS	AETNA
(___)	POS	AIG
(___)	POS	ALLSTATE
(___)	POS	AMERICAN BANKERS INSURANCE GROUP
(___)	POS	AMERICAN POSTAL WORKERS
(___)	POS	AMERIHEALTH
(___)	POS	ANTHEM HEALTH & LIFE
(___)	POS	ATLANTIC HOME CARE AND HOSPICE
(___)	POS	CIGNA HEALTHCARE
(___)	POS	CNA PHCS
(___)	POS	CORESOURCE
(___)	POS	CORESOURCE PHCS
(___)	POS	ETHIX
(___)	POS	GUARDIAN PHCS
(___)	POS	HORIZON BCBSNJ
(___)	POS	INDENDENCE BC MAGELLAN
(___)	POS	JOHN ALDEN PHCS
(___)	POS	KEYSTONE HEALTH PLAN
(___)	POS	LIBERTY MUTUAL NO FAULT
(___)	POS	LINCOLN NATIONAL
(___)	POS	MAGELLAN
(___)	POS	MASS MUTUAL
(___)	POS	MEDICHOICE NETWORK INC
(___)	POS	MMH EMPIRE BCBSNY
(___)	POS	PHOENIX
(___)	POS	PRIVATE HEALTHCARE SYSTEMS
(___)	POS	PROVIDENT LIFE
(___)	POS	PRUDENTIAL
(___)	POS	TIME FORTIS
(___)	POS	WELLCHOICE EMPIRE HMO PPO POS
(___)	PPO	AARP
(___)	PPO	ADVANCED HEALTHCARE SYSTEMS
(___)	PPO	AETNA
(___)	PPO	AIG
(___)	PPO	ALLSTATE
(___)	PPO	AMERICAN BANKERS INSURANCE GROUP
(___)	PPO	AMERICAN POSTAL WORKERS
(___)	PPO	AMERIHEALTH
(___)	PPO	AMERIHEALTH MAGELLAN
(___)	PPO	ANTHEM HEALTH & LIFE
(___)	PPO	ATLANTIC HOME CARE AND HOSPICE
(___)	PPO	CIGNA HEALTHCARE
(___)	PPO	CNA PHCS
(___)	PPO	CORESOURCE
(___)	PPO	CORESOURCE PHCS
(___)	PPO	ETHIX
(___)	PPO	GREAT WEST
(___)	PPO	GUARDIAN PHCS
(___)	PPO	HORIZON BCBSNJ
(___)	PPO	HORIZON HEALTHCARE INS OF NY
(___)	PPO	JOHN ALDEN PHCS
(___)	PPO	KEYSTONE HEALTH PLAN
(___)	PPO	LIBERTY MUTUAL NO FAULT
(___)	PPO	LINCOLN NATIONAL
(___)	PPO	MAGELLAN
(___)	PPO	MASS MUTUAL
(___)	PPO	MMH EMPIRE BCBSNY
(___)	PPO	PHOENIX
(___)	PPO	PRIVATE HEALTHCARE SYSTEMS
(___)	PPO	PROVIDENT LIFE
(___)	PPO	PRUDENTIAL
(___)	PPO	QUALCARE
(___)	PPO	TIME FORTIS
(___)	PPO	WELLCHOICE EMPIRE HMO PPO POS
(___)	WC	AIG
(___)	WC	FIRST MANAGED CARE OPTION
(___)	WC	INSERVCO

(___)	WC	LIBERTY MUTUAL NO FAULT	(___)	WC	STATE FARM
(___)	WC	NJ MANUFACTURERS WORKERS COMP	(___)	WC	TRAVELLERS WORKERS COMPENSATION
(___)	WC	SCIBAL ASSOCIATES WORKERS COMP	(___)	WC	WAUSAU INS CO WORKERS COMP
(___)	WC	SELECTIVE INS	(___)	WC	WORKERS COMP OTHER

Payments Types [____]MC [____]Visa [____]Discover [____]Am Ex [____]Cash [____]Check

(__) No, I do NOT want to participate in the Physician Referral service. Please complete your name on page one. Sign and date the lines below, and return this questionnaire to the address indicated on the cover letter to be removed from the Referral Roster.

(__) Yes, I want to participate in the Physician Referral service.
I authorize you to release any of the information enclosed in this questionnaire to members of the community who call the Physician Referral Service in need of healthcare services. Please fax back the completed questionnaire to 973-429-6537.

Physician Signature _____ Date _____