Insurance Referral Request

HeartPlace and _____ have a mutual patient.

The patient listed below requires a referral in order to be seen by our provider.

_____ _____

Patient Name: Patient DOB:

Rajjit Abrol, M.D.
Electrophysiologist
Phone: 469-467-6655
Fax: 972-341-3403

In our office on _____/_____/_____ and **current DX** _____

Please fax this information to **972-341-3403** and include this request as your cover sheet. Your prompt attention to this matter is greatly appreciated.

Thank you,

HeartPlace