RECIPIENT INFORMATION

Full Name: [Provider Name]
Title: [e.g., MD, DO, NP, PA]
Department: [e.g., Cardiology, General Practice]
Facility Name: [Hospital or Clinic Name]
Street Address: [Street Number and Name]
Suite/Unit: [Suite Number]
City: [City Name]
State: [State/Province]
Zip Code: [Postal Code]

CONTACT INFORMATION

Office Phone: [Phone Number]
Office Fax: [Fax Number]
Email Address: [Email Address]
NPI Number: [National Provider Identifier]

PATIENT REFERENCE

Patient Name: [Full Patient Name]
Date of Birth: [MM/DD/YYYY]
Medical Record Number: [MRN]