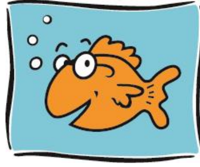

Children's Eye Center of South Texas, PA
Charles S. McCash, M.D.
Keith Williams, O.D.
1314 E. Sonterra, Ste 5201
San Antonio, TX 78258

Pediatric Ophthalmology Referral Form

Date of Request:___________________

Referring Physician________________ Referring Physician Phone__________________

Reason for Referral: ____

____

Patient Name:_______________________DOB:_______________ Gender:__________

Telephone:____________________Address:_____________________________________

Guarantor Name:____________________ Guarantor DOB:_______________________

Primary Insurance:__________________________ID#:___________________________

Secondary Insurance:________________________ID#:___________________________

Please send insurance card, demographics, radiology reports and last visit notes if available. If patient requires authorization, such as an HMO or other Managed Care Plan, please request and send authorization number, required visits and any other pertinent information. Thank you.

Telephone: (210) 340-6633
Fax: (210) 340-6390
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