



# INTER-OFFICE TRANSFER

DO NOT USE THIS FORM FOR MEDICAL RELEASES

## Part 1. TO BE FILLED OUT BY PATIENT

Subscriber: \_\_\_\_\_  
(Person who Subscribes to Insurance)

Date of Birth: \_\_\_\_\_ Insurance \_\_\_\_\_

Telephone: Home (    ) \_\_\_\_\_ Work (    ) \_\_\_\_\_

I, the above subscriber of this insurance, wishes to transfer the insurance and all medical records of the individuals listed below:

**FROM:** Pioneer Medical Group of \_\_\_\_\_

**TO:** Pioneer Medical Group of \_\_\_\_\_

I understand that my insurance company will be advised of the transfer if required. I also understand this transfer may take 2-3 weeks to process.

List all individuals affected by the above transfer including the subscriber:

Family Member	Date of Birth	Medical Record #	Family Member	Date of Birth	Medical Record #
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Reason for Transfer: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature of Subscriber) (Date)

## Part 2. TO BE COMPLETED BY RECEPTIONIST

1. Enter Medical Record number on all Patients. Receptionist Initials: \_\_\_\_\_
2. Forward to Chart Home Base.