



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:

Sumeet Chhabra, M.D.
Electrophysiologist
PHONE: 972-591-5322
FAX: 844-292-1461

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

Please fax this information to **844-292-1461** and include this request as your cover sheet.
Your prompt attention to this matter is greatly appreciated.

Thank you,

HeartPlace