MED CENTER SPECIALTY PHARMACY
A BIOMATRIX Specialty Company

Feb 2018

ANEMIA PRESCRIPTION REFERRAL FORM

3100 MacCorkle Avenue S.E. Suite 100 Charleston, WV 25304
TEL: 304-344-8021 FAX: 304-344-0655

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Code Diagnosis Weight Allergies

Testing ☐ Yes ☐ No Results Patient currently on therapy ☐ Yes ☐ No Date of next blood work

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRESCRIPTION # 1

Medication	Dosage	Quantity	Directions for use	Refills	Signature

PRESCRIPTION # 2

Medication	Dosage	Quantity	Directions for use	Refills	Signature

PRESCRIPTION # 3

Medication	Dosage	Quantity	Directions for use	Refills	Signature

PRESCRIPTION # 4

Medication	Dosage	Quantity	Directions for use	Refills	Signature

PRESCRIPTION # 5

Medication	Dosage	Quantity	Directions for use	Refills	Signature

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

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Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit us at **WWW.MEDCENTERSPECIALTYPHARMACY.COM** for online fillable forms.

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