



# GENERAL REFERRAL FORM

TEL 813.880.2500  
FAX 813.880.2501  
TOLL FREE 1.866.880.2507

## PATIENT INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Allergies: \_\_\_\_\_ Ship to:  Patient  Clinic

## INSURANCE

Prescription Card: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ ID# \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_  
Group: \_\_\_\_\_ ( Please attach copies of insurance cards. )

## DIAGNOSIS

ICD-10: \_\_\_\_\_ Current Medications: \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refill
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## PRESCRIBER INFORMATION

Physician Name: \_\_\_\_\_ Address: \_\_\_\_\_  
State License#: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Office Contact Name /Number: \_\_\_\_\_  
Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.  
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