Nephrology Enrollment Form

InfuCare Rx

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION

Name:
Address:
City: | State/Zip:
Telephone: | DOB: | M F
Language Preference: | Wt: | Ht:

PRESCRIBER INFORMATION

Prescribing Practitioner: | NPI:
Address:
City: | State/Zip:
Office: | DEA:
Contact: | Phone: | Fax:

PRIMARY INSURANCE INFORMATION

Member Name: | M F | DOB:
Address: | City:
State: | Zip: | Telephone: | Alt. Telephone:
Member ID: | Rx Group #: | BIN#:
PCN#: | Customer Service #: | Please attach a copy of the front and back of the patient's insurance card, if available.*****

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

PRESCRIPTION

New Refill | Ship by: | Ship to: Patient's Home Doctor's Office Other:____________________

Drug	Strength	Directions	Quantity	Refills
Aranesp®			1 month supply	
Epogen®			1 month supply	
Procrit®			1 month supply	
Rayaldee®	30 mcg 60 mcg	Take 1 capsule by mouth daily	1 month supply	
Samsca®			1 month supply	
Sensipar®			1 month supply	
Zemplar®			1 month supply	

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

ICD-10 and Diagnosis:

Prior Medication Failed: ____
Length of Treatment:____
Reason for Discontinuation: ____

Lab Results: Hematocrit: _______________% Hemoglobin: ________________%
Date: ____/_____/_________ Date: _____/_____/__________

Platelets: ________________%
Date: _____/_____/__________

Serrum Ferrite: ________________ng/mL Transferrin Saturation (TSAT):________________
Date: ____/____/________ Date: ____/____/________

Additional Clinical Information:

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: | **Date:**