

Phone: (888) 571-3100 • Fax: (800) 582-9315

Date: _____

Demographics

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Sex: Male Female
Phone: (home) _____
(work) _____
(cell) _____
Social Security Number: _____
Next of Kin: _____
Height: _____ Weight: _____

Physician Orders: *(Please check the following)*

Pegasys _____ mcg SQ weekly x _____ weeks
 Peg-Intron _____ mcg SQ weekly x _____ weeks
 Ribavirin _____ x _____ weeks

 Skilled Nursing visits as required for teaching
 Teaching to be done by physician office
 Standard supplies as requested

Insurance Information:

Primary Insurance: _____
Member ID #: _____ Group #: _____
Policy Holder: _____ Relationship: _____
Secondary Insurance: _____
Member ID #: _____ Group #: _____
Policy Holder: _____ Relationship: _____

Prescribing Physician:

Name: _____
Address (please include facility name):

Phone: _____ Fax: _____
Specialty: _____
License #: _____ UPIN #: _____
DEA #: _____ NPI #: _____

I have read this entire form and verify to its accuracy Yes
Date: _____

Diagnosis:

Hepatitis C ICD-9 Code: _____
Genotype: _____

Allergies: _____
Date of last dose (if applicable): _____

Please _____ to email this form automatically, or attach manually to: referrals@medprorx.com

Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)

MedPro Rx, Inc. is compliant with HIPAA Guidelines