



PATIENT REFERRAL FORM

PATIENT INFORMATION

Patient Name, SSN#, DOB, Address, City, State, Zip, Home Phone, Cell Phone, Height, Weight, Gender: Male Female

INSURANCE INFORMATION

Insurance Co, Phone, Policy#, Group # (repeated twice)

PRESCRIPTION INFORMATION

Medication, Qty, Dose, Refills, Generic (checkbox) (repeated three times)

PHYSICIAN INFORMATION

Prescriber Name, Phone, Fax, Office Contact, Email, NPI#, DEA#

NOTES: (Large empty box for notes)

VALID SIGNATURE REQUIRED: A valid signature from a physician is required to process the referral form. For questions please call, 1-888-292-0744

Deliver to: MD Office Patient Home, Injection Training: Office to Instruct Patient Home BioPlus to Arrange Teaching

Completion of this form authorizes BioPlus Specialty Pharmacy to contact the patient's insurance company and confirm coverage for the prescribed medications. Should there be no insurance coverage found or high out of pockets cost, BioPlus will seek alternate means for coverage on the patient's behalf.

FAX to BioPlus Specialty Pharmacy at 800-269-5493

* Prescriber Signature: _____ Date: _____