BIOMATRIX SpRx

GENERAL REFERRAL FORM

NOT FOR CONTROLLED SUBSTANCES

TODAY'S DATE _____

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ**
TEL: 877-567-8087 FAX: 877-567-8089

☐ **BiologicTx - CA**
TEL: 800-404-1963 FAX: 800-404-4595

☐ **BiologicTx - IL**
TEL: 888-892-7607 FAX: 877-567-8089

☐ **Decillion Healthcare**
TEL: 800-622-9321 FAX: 866-548-8849

☐ **Elwyn Specialty Care**
TEL: 855-359-9679 FAX: 610-545-6030

☐ **Factor Support Network**
TEL: 877-376-4968 FAX: 805-482-6324

☐ **Matrix Health**
TEL: 877-337-3002 FAX: 888-385-2805

☐ **Med Center Specialty Pharmacy**
TEL: 855-633-5633 FAX: 304-344-0655

☐ **MedEx BioCare**
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____

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# _____

ICD-10 Code: _____ Diagnosis: _____

Testing ☐ Yes ☐ No Results_____

Patient currently on therapy ☐ Yes ☐ No Date of next blood work_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **MEDICATION #1:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #2:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #3:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #4:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #5:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #6:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ *Dispense as written* **Date**_____

Prescriber's Signature (signature required. NO STAMPS)_____ *Product Substitution Permitted* **Date**_____

Please visit **WWW.BIOMATRIXSPRX.COM** For more information