meijer specialty pharmacy

P: 1-855-263-4537 • F: 1-877-222-5036
www.MeijerSpecialtyPharmacy.com

General Referral Form

Physician Information

Send updates to: ◯ Fax: ______ ◯ Email: ______ ◯ Text: ______

Prescriber Name:			◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:			Practice name/Supervising MD:	
Address:			City:	
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Medical History | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Has patient been treated previously for this condition? ◯ Y ◯N	Medication(s):
Is patient currently on therapy? ◯ Y ◯N	Medication(s):
Will patient stop taking the above medication(s) before starting the new medication? ◯ Y ◯N	**If Yes** How long should patient wait before starting the new medication?
Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):	
Primary Diagnosis: (ICD-10/Diagnosis Code & Description)	
TREATMENT ARRANGEMENTS:	Ship Meds: ◯ Home ◯ Doctor's Office

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
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◯				
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◯				

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

Physician Signature: Date	Physician Signature: Date
Substitution Permitted	Dispense as Written