

# ONCOLOGY REFERRAL FORM

Phone (888) 370.1724 Fax (877) 645.7514  
10004 S. 152nd St, Suite A, Omaha NE 68138



| Patient Information   |               |              |                         |            |           |
|---|---------------|--------------|-------------------------|------------|-----------|
| Last Name   |               | First Name   |                         | Home Phone |           |
| Home Address  |               | City         |                         | State      | ZIP       |
| Shipping Address (if different from above)                  |               | City         |                         | State      | ZIP       |
| Social Security Number                                      | Date of Birth | Gender (M/F) | Height                  | Weight     | Diagnosis |
| Special Instructions (allergies, language preference, etc.) |               |              |                         |            |           |
| Primary Caregiver/Phone                                     |               |              | Emergency Contact/Phone |            |           |

| Healthcare Provider Information: *Indicates Required Field |                |                                |       |                 |      |
|--|----------------|--------------------------------|-------|-----------------|------|
| Practice/Facility Name                                     |                | Physician First and Last Name* |       | Phone*          | Fax  |
| Address*   |                |                                | City* | State*          | ZIP* |
| Physician NPI#*  | Physician DEA# | Physician State License #      |       | Physician UPIN# |      |
| Nurse/Key Contact  |                | Phone or Pager Number          |       | Email           |      |

| Insurance Information <i>Fill out entirely OR fax a copy of patient's insurance card - both sides</i> |       |                     |           |              |
|---|-------|---------------------|-----------|--------------|
| Primary Insurance   | Phone | Name/SSN of Insured | ID Number | Group Number |
| Secondary Insurance   | Phone | Name/SSN of Insured | ID Number | Group Number |
| Other Insurance/Prescription Drug Vendor (Rx Bin #)   |       |                     |           |              |

| Additional Information |                  |  |                    |
|------------------------|------------------|--|--------------------|
| Today's Date           | Date Meds Needed | May we contact this patient?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Primary ICD-9 Code |

| Medication | Dose/Strength | Directions for Use | Quantity | Refills |
|------------|---------------|--------------------|----------|---------|
| 1.         |               |                    |          |         |
| 2.         |               |                    |          |         |
| 3.         |               |                    |          |         |
| 4.         |               |                    |          |         |
| 5.         |               |                    |          |         |
| 6.         |               |                    |          |         |
| 7.         |               |                    |          |         |
| 8.         |               |                    |          |         |
| 9.         |               |                    |          |         |
| 10.        |               |                    |          |         |

\*\*\*When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards\*\*\*

**Physician Signature:** \_\_\_\_\_  **DAW (Dispense as Written) Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
I authorize Amber Specialty Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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