ONCOLOGY REFERRAL FORM

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

AMBER™ SPECIALTY PHARMACY

Patient Information

Last Name	First Name	Home Phone	Work/Mobile 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 *Fill out entirely OR fax a copy of patient's insurance card - both sides*

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?	Primary ICD-9 Code
		❑ Yes ❑ No	

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.