Amber PHARMACY

Transplant Intake 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	Work/Mobile Phone

Home Address	City	State	ZIP

Temporary Address or Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Date of Birth	Gender (M/F)	Weight	Height	Diagnosis/Transplant Type

Special Instructions (language preference, etc.)	Allergies	Date of Transplant

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 UPIN#	Physician DEA#	Physician State License #

Nurse/Key Contact	Phone or Pager Number	Email

Insurance Information

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 #)

Transplant Information

Today's Date	Date Admitted	Discharge Date	Date Meds Needed	Special Instructions

Medication	Dose/Strength	Sig	Qty.	Refills
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

*****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 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.