



# 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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.