Specialty by birdi

Specialty Prescription and Enrollment Form

Phone: (877) 437-9012 Fax: (877) 309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____

Date of Birth: _____ Gender: ☐ Male or ☐ Female

Address: _____

City: _____State: _____Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail:_____

Please attach copy of front and back of patient's prescription ins. card(s) if applicable

Insurance Company Name: _____

Insurance Company Phone: _____

Policy holder:_____

Policy holder Employer:_____

Relationship to Patient:_____

ID# _____Group#_____

RxBIN: _____RxPCN:_____

Prescriber Information

Practice/Organization Name: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#:_____Fax#:_____

DEA#_____NPI#_____

License#:_____Medicaid UPIN#:_____

Physician Specialty: _____

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Clinical Information and Prescription

Primary Diagnosis: ICD-10 Code: _____

Description: _____

Date of Diagnosis or Years with Disease: _____

Patients Allergies: _____

_____

Latex allergy: ☐ Yes ☐ No

Patient Weight: _____ Patient Height: _____ Date: ____/____/____

℞

Quantity: _____ **Refills Authorized**: _____

Date Shipment Needed: _____ **Ship to:** ☐ **Patient** ☐ **Prescriber** ☐ **Clinic**

Shipment Address: _____Attn: _____

City: _____State: _____Zip:_____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X_____ **Date:** _____/_____/_____

Physician Signature (no stamps)

If physician requests Brand Name only,
DAW MUST be HANDWRITTEN in the following space provided: