



Referral Form

Phone 877.421.3405 Fax 877.421.3406
546 West Las Tunas Drive, San Gabriel, CA 91776

Patient Information				
Name (last, first)		Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell		Date of Birth
Home Address, City, State				ZIP
Shipping Address, City, State (if different from above)				ZIP
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies		
Healthcare Provider Information				
Prescriber's First and Last Name		Phone	Fax	
Address, City, State				ZIP
Nurse/Key Contact	Physician NPI	DEA	License	
Insurance Information <i>(attach copies of card and fax along with this form)</i>				
Primary Insurance	Phone	Name (Insured <input type="checkbox"/> Self, <input type="checkbox"/> Spouse, <input type="checkbox"/> Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured <input type="checkbox"/> Self, <input type="checkbox"/> Spouse, <input type="checkbox"/> Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN
Additional Information				
Today's Date	Start Date	Deliver to: <input type="checkbox"/> Home <input type="checkbox"/> Physician	Nurse Training Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Instructions
Clinical Information				
Diagnosis		ICD 9	Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Weight		Height	Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications tried and failed to treat this diagnosis: _____				
Physician's Orders				
Dose/Quantity/Direction:				
Refill #: _____				

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature: _____ Date ____/____/____

I authorize MedQuick 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 NOTICE: The information contained in this transmittal belongs to Med Quick Prescription Shoppe and may include information that is confidential, privileged and protected from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this document in error, please immediately notify us by phone at 877-421-3405, and then destroy this document. Thank you.