vitalcare SPECIALTY

VITAL CARE RX

Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or **send patient demographic sheet**.)

Please fax copy of patient's insurance card including both sides

Name: _____

DOB: _____Gender: M / F Height: _____ Wt: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Last 4 digits SS#: _____ Email: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State Lic. #: _____ NPI: _____

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact: _____

Phone: _____ Email: _____

Please Send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Authorization Processing

ICD-10 Code: _____ Primary Diagnosis: _____ BSA: _____

Other Diagnosis: _____

Allergies: _____

Therapy: ☐ New ☐ Restart Prior Therapies: _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills

Medication	Dose	Directions	Quantity	Refills

Deliver To: ☐ Home ☐ Physician * If shipped to physician's office, physician accepts on behalf of patient for administration on office

Prescriber Signature _____ Date _____ Brand Name Required? ☐ Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.