General Enrollment Form

Fax Referral To: 318-769-0809
Phone: 318-841-6416

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____

Email:_____

DOB: _____ Gender: Male / Female

Preferred Language if other than English: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

NPI#: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

Contact Person: _____

Contact's Phone/ Email: _____

INSURANCE INFORMATION

[Please FAX copy of prescription cards (front and back) with this form, if available]

Primary Insurance: Name of Insurer: _____ ID #: _____

Rx BIN: _____ Rx PCN: _____ Rx Group: _____

Secondary Insurance: Name of Insurer: _____ ID #: _____

Rx BIN: _____ Rx PCN: _____ Rx Group: _____

DIAGNOSIS AND CLINICAL INFORMATION

(Please FAX recent labs and clinical notes with prescription to expedite Prior Authorization)

ICD-10 Code Diagnosis Description

_____

_____

Date of Diagnosis: _____

Needs by Date: _____

New Therapy / Reauthorization / Restart of Therapy

Current Therapy:_____

Will the Patient be stopping the above medication before starting therapy? If yes, date of discontinuation?

_____

Has the Patient failed other therapies in the past? _____

If yes, please list: _____

Patient Clinical Information

Allergies with reaction:

_____

_____

_____

Patient Weight: _____

Current Medications:

_____

_____

_____

_____

Additional Comments: