Patient Prescription Form

OncologyRx
Care Advantage™

Physician Information

Physician Name: ______________________

Practice Name: ______________________

Street Address: ______________________

City: ____________ State: ____ ZIP: ________

Office Contact: ______________________

Phone: ____________ Fax: ____________

Office Contact E-mail: ______________________

NPI #: ____________ DEA #: ____________

Patient Information & Diagnosis

Patient Name: ______________________

Patient Address: ______________________

City: ____________ State: ____ ZIP: ________

Date of Birth: ____________ Gender: ❒ Male ❒ Female

Height: ____________ Weight: ____________

Home Phone: ____________ Cell/Work Phone: ____________

Patient Diagnosis: ______________________

Diagnosis ICD-9 Code: ______________________

Allergies: ______________________

HIPAA Contact: ______________________

Relationship: ______________________

Home Phone: ____________ Cell/Work Phone: ____________

Patient Insurance Information

Please complete or include enlarged copy of insurance card (front & back).

Medicare/Medicaid ID # (if eligible): ______________________

Medicare Supplement Plan: ______________________

ID #: ____________ Phone #: ____________

Medicare Part D Plan: ______________________

ID #: ______________________

Rx BIN: ____________ Rx PCN: ____________

RX Group #: ______________________

Insurance Plan: ______________________

ID #: ______________________

Group #: ______________________

Phone #: ______________________

Sign & Fax to 1-866-423-2979

Physician Signature: ______________________

Date: ______________________

Faxed by: ______________________
(Name)

Prescription

Complete this section or provide prescription.

Refills: ____________

Date: ____________

You should receive an e-mail or fax confirmation that the form was received. Please note that if you do not receive a confirmation from Care Advantage, there may have been a faxing error. Please check your fax machine for completed transmission. If completed and no confirmation was received, then call 1-888-4RXMEDS to verify your order.

OCA.0015.B.0808