



# Oncology Referral Form

Phone (888) 370.1724 Fax (877) 645.7514  
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information					
Last Name		First Name		Home Phone	
Home Address			City	State	ZIP
Shipping Address (if different from above)			City	State	ZIP
Social Security Number	Date of Birth	Gender (M/F)	Weight	Diagnosis	
Special Instructions (allergies, language preference, etc.)					
Primary Caregiver/Phone			Emergency Contact/Phone		

Healthcare Provider Information: *Indicates Required Field					
Practice/Facility Name		Physician First and Last Name*		Phone*	
Address*			City*	State*	ZIP*
Physician NPI#*	Physician DEA#	Physician State License #		Physician UPIN#	
Nurse/Key Contact		Phone or Pager Number		Email	

Insurance Information <i>Fill out entirely OR fax a copy of patient's insurance card - both sides</i>				
Primary Insurance		Phone	Name/SSN of Insured	ID Number
Secondary Insurance		Phone	Name/SSN of Insured	ID Number
Other Insurance/Prescription Drug Vendor (Rx Bin #)				

Additional Information			
Today's Date	Date Meds Needed	May we contact this patient?	Primary ICD-9 Code
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medication	Dose/Strength	Directions for Use	Quantity	Refills
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

\*\*\*When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards\*\*\*

**Physician Signature:** \_\_\_\_\_  **DAW (Dispense as Written) Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
I authorize Amber 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 Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.