MEDQUICK PHARMACY

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 ❑ Home ❑ Cell	Date of Birth
Home Address, City, State		ZIP
Shipping Address, City, State (if different from above)		ZIP

Social Security Number	❑ Male ❑ 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 *(attach copies of card and fax along with this form)*

Primary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No	Special Instructions

Clinical Information

Diagnosis	ICD 9	Has patient been treated previously for this condition? ❑ Yes ❑ No Is patient currently on therapy? ❑ Yes ❑ No
Weight	Height	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.