

Referral Checklist

REFERRING OFFICE, ALSO FAX:

- Order
- Most recent labs
- Supporting clinical notes

Fax to 505.843.7813 or

Email to intake@optimuminfusion.com

NOTE: When sending a referral, the Referral Checklist is not required. The information specified must be included, either on this form or on attached documentation. Optimum Infusion recommends using its therapy-specific order forms to accelerate prior authorization.

Patient Demographics

Patient demographics attached (If YES, you may skip the Patient Demographics section.)

Patient Name _____ DOB _____ Gender _____

Address _____ Email _____

City, State, Zip Code _____ Home Phone _____

Enrolled in Funded Program? ____ Yes ____ No ____ N/A Mobile Phone _____

Patient is interested in patient support programs

Patient Insurance

Front and back of insurance card attached (If YES, you may skip the Patient Insurance section.)

Primary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Secondary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Order, Diagnosis, and Clinical Information

Order, Diagnosis and Clinical Information attached

(Go to www.optimuminfusion.com/referrals to download a therapy-specific order form and review the supporting clinicals.)

Contact Information*

Contact Information attached (If YES, you may skip the Contact Information section below.)

Contact Name _____ Practice Name _____

Title _____ Phone _____ Email _____