Referral Checklist

REFERRING OFFICE, ALSO INCLUDE:

- Order
- Most recent labs
- Supporting clinical notes

Fax to 505-420-4848 or
Email to refer@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_____

☐ How Did You Hear About Optimum Infusion

☐ Existing Referring Partner ☐ Advertising ☐ Word-of-Mouth ☐ Other _____

☐ Patient Self-Referral ☐ Online Search ☐ Community Event

☐ Hospital / Facility Referral ☐ Website ☐ CME