Hy-Vee health

PHYSICIAN Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ______ **DOB:** ______ **Phone:** ______

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** ______

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Diagnosis: ______ **ICD-10 Code:** ______

Patient Weight: ______ lbs. (required) **Allergies:** ______

Physician Order

Lab Orders: ______

Frequency: ______

Other orders: ______

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: ______ **Signature:** ______ **Date:** ______

Provider NPI: ______ **Phone:** ______ **Fax:** ______ **Contact Person:** ______

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ______

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX Phoenix, AZ Other ______

HY-VEEHEALTHINFUSION.COM

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COMPREHENSIVE SUPPORT FOR INFUSION THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & Insurance Approval

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
- Labs attached (if applicable)
- Diagnostics attached (if applicable)
- Medical necessity (if applicable): ______________________

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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