BIOMATRIX SpRx

BLEEDING DISORDERS PATIENT REFERRAL FORM

TODAY'S DATE _____

PLEASE FAX REFERRAL FORM TO:

- ☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
- ☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
- ☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
- ☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
- ☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
- ☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
- ☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
- ☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
- ☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

REFERRAL INFORMATION

Referral Type: ☐ New Referral ☐ On-Service Patient ☐ Existing Patient (Previously DCed)
Referred By _____ Nursing Required? ☐ No ☐ Yes
Who is servicing the patient? _____

PATIENT INFORMATION

Last Name _____ First name _____ MI _____
DOB_____ Minor? ☐ No ☐ Yes
Street Address _____ City _____ State _____ Zip _____
Tel _____ Alternate Tel _____ Email _____

CLINICAL INFORMATION

Additional clinical information required prior to shipping medications

Diagnosis _____ Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Inhibitor
Product _____ Dose _____ Shipment needed by _____
Referring Physician _____ Phone _____ State _____

INSURANCE INFORMATION

Attach copies of insurance cards (front and back)

Insured's Name _____ DOB_____ Relation to Patient _____
Insured's Employer _____ Employer Phone _____
Primary Insurance _____ Insurance Phone _____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare# _____ State_____
Member ID _____ Group # _____ RX Phone _____
RX Drug Plan _____ BIN# _____ PCN# _____
RX ID# _____ RX Group# _____

SECONDARY INSURANCE

if applicable

Insured's Name _____ DOB_____ Relation to Patient _____
Insured's Employer _____ Employer Phone _____
Primary Insurance _____ Insurance Phone _____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare# _____ State_____
Member ID _____ Group # _____ RX Phone _____
RX Drug Plan _____ BIN# _____ PCN# _____
RX ID# _____ RX Group# _____