MedImpact Direct Specialty™

Specialty Medication Referral Form

Fax (888) 807-5716
Toll-Free Phone (877) 391-1103

Date Needed: _____

Note: This form is intended for prescriber use only. If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

Patient Information

Last Name	First Name	Date of Birth	Gender M F

Home Phone	Work or Mobile Phone	Email Address (Email used for order status updates)

Address		

City	State	Zip Code

Patient Insurance Information

Medical Insurance (Please include copy of front and back of card)	Prescription Card Phone

Subscriber Name	

Policy #	BIN/PCN #

Medicare Number	Medicaid Number

Relationship to Patient ☐ Self ☐ Other _____	Prescription Card ☐ Yes ☐ No

Clinical Information

Medicare Number	Medicaid Number

Patient Weight _____ ☐ lbs ☐ kg (check one)	Height _____	☐ Patient is New to Therapy ☐ Patient is Restarting Therapy ☐ Patient is Currently on Therapy (Start Date: _____)

Allergies	Diagnosis	ICD-10

Deliver to: ☐ Patient's Home ☐ Prescriber Office ☐ Other _____

IMPORTANT WARNING: This is intended for the use of the person or entity to whom it is addressed and contains sensitive, confidential information, the disclosure of which may be governed by federal and/or state law. If you are not the intended recipient, or responsible for delivering it to the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Prescriber Information

Prescriber Last Name	Prescriber First Name	MD DO NP PA
Prescriber Address		
City	State	Zip Code
Phone	Fax	Backline Phone Number
License #	NPI #	UPIN #	DEA #
Office Contact	Supervising Physician (if applicable)	

Prescription: Write prescription here and fax to MedImpact Direct Specialty.

Patient's Name

Patient's Date of Birth

Prescriber's Signature

I certify that the therapy is medically necessary and that the information above is accurate to the best of my knowledge. I authorize MedImpact to act on my behalf as my agent for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient's benefit plan. **Prescriber's Signature Required:**

X _____ Generic Substitution Permitted

X _____ Dispense As Written

_____ Printed Name

Date: _____

☐ **Hold shipment until notified by prescriber**

CONFIDENTIAL HEALTH INFORMATION: This form contains health information protected under federal and state confidentiality laws, including but not limited to the Health Insurance Portability and Accountability Act and its implementing regulations (HIPAA). I certify that I have received the appropriate authorization from the patient, if required, and met any other applicable requirements imposed under federal and/or state law, including but not limited to HIPAA, needed to send this information to MedImpact Direct Specialty HUB (MedImpact) and its contracted pharmacies for the purposes of verifying the patient's insurance coverage and providing information on appeals for denied claims.

Prescriber must manually sign (rubber stamps, signature by other office personnel for the prescriber, and computer generated signatures will not be accepted).