

Hematology/Oncology Referral Form

 **HealthCare**
The Power of Advanced Medicine
Department of Pharmacy Services
www.UKSpecialtyPharmacy.org

UK Specialty Pharmacy
800 Rose Street HC201
Lexington, KY 40536
Phone 859-218-5413
Fax 859-257-8626

DATE: _____ DELIVER TO CLINIC: _____ MAIL TO PATIENT: _____ PICKUP AT KCP: _____ OTHER: _____
ICD-10 CODE: _____ ANTIICIPIATED START DATE: _____

PATIENT INFORMATION	<input type="checkbox"/> Male <input type="checkbox"/> Female	SHIPPING INFORMATION	<input type="checkbox"/> same
Name: _____		Shipping Address: _____	
Address: _____		City, State, Zip: _____	
City, State, Zip: _____		Will UPS deliver to your house? <input type="checkbox"/> yes <input type="checkbox"/> no	
DOB: _____ SSN: _____		Will FedEx deliver to your house? <input type="checkbox"/> yes <input type="checkbox"/> no	
Home Phone: _____		PACKAGING REQUEST	
Cell/Alternate Phone: _____		<input checked="" type="checkbox"/> Child Resistant Lids	<input type="checkbox"/> Easy Open Lids

I certify that all the information on this form is correct , including any selections made for sending my order signature required or with non-child resistant (easy open) caps. I permit UK Specialty Pharmacy to release all information on this form concerning prescription orders to my plan sponsor, administrator, or health plan for the purpose of payment, treatment, or healthcare operations.

Patient Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____
Phone Number: _____
(Different from Patient number)

DOCUMENT CHECKLIST (for staff)

- Medicare Suppliers Standards given
- UK HealthCare Patient Rights given
- Notice of Privacy Practices given
- Insurance Information complete

THIS ASSIGNMENT OF BENEFITS IS FOR:

- Anti Cancer Meds

This Intake Form is used in lieu of patient's or his/her representative's signature on the HICFA 1500 and on other health insurance claim forms. Any person who misrepresents or falsifies information can be subjected upon conviction to fines and imprisonment. The undersigned certifies that they are the patient, or is duly authorized to execute this consent and accept its terms as or on behalf of the patient and has read the information and understands and agrees to the terms hereof as or on behalf of the patient. The undersigned being the patient or his/her representative desires to purchase the medication or supplies from UK HealthCare Ambulatory Pharmacies.

I have received a copy of the Medicare Suppliers Standards, UK Healthcare Notice of Privacy Practices and Your Rights and Responsibilities as a UK HealthCare Patient. I also acknowledge that I have received instruction/training on the medication and supplies provided to me. I authorize the release of my medical or other information necessary to process the claim. I also request payment of Medicare or insurance benefits to UK HealthCare Ambulatory Pharmacy. I agree to pay all co-payments, deductibles and non-covered services.

Patient Signature: _____ Date: _____

If Power of Attorney or Spouse is signing on behalf of the patient, please sign Patient's Name **by** Signer's Name (reason patient cannot sign)