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:_____ ANTICIPIATED START DATE:_____

PATIENT INFORMATION ☐Male ☐Female

Name: _____

Address:_____

City, State, Zip: _____

DOB:_____ SSN:_____

Home Phone: _____

Cell/Alternate Phone:_____

SHIPPING INFORMATION ☐ same

Shipping Address:_____

City, State, Zip: _____

Will UPS deliver to your house? ☐ yes ☐ no

Will FedEx deliver to your house? ☐ yes ☐ no

PACKAGING REQUEST

☒ Child Resistant Lids ☐ 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)*