60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: ____________

☐ NEW PATIENT ☐ CURRENT PATIENT

General Prescription Referral Form

PATIENT INFORMATION

Patient Name ____________

Address ____________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug Allergies ____________ ☐ Male ☐

Patient Weight: ____________ Height: ____________

PRESCRIBER INFORMATION

Prescriber Name ____________ Lic# ____________

DEA# ____________ NPI ____________

Practice Name ____________

Address ____________ Suite ____________

City ____________ State ____________ Zip ____________

Office Phone ____________ Fax ____________

Office Contact ____________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________

Policy # ____________ Group ____________

Insurance Phone ____________

Prescription Drug Coverage: Company ____________

Secondary Insurance (if applicable) ____________

Policy # ____________

Insurance Phone ____________

Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# *(if available)* ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Primary Diagnosis: ____________ ICD-10: ____________

Currently on therapy: ☐ Yes ☐ No ____________ Date Treatment Started: ____________

Pertinent PMH/Diagnostic Testing: ____________

____

____

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QTY	REFILLS

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

If applicable: ☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ____________ Date ____________

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