



**PHYSICIAN
INFUSION ORDERS**

P: 877.365.5566 | F: 855.889.2946

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

Diagnosis: _____ **ICD-10 code:** _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

PHYSICIAN ORDER

Lab Orders: _____ **Frequency:** _____

Other Orders: _____

PROVIDER INFORMATION Orders are good for one year from the signature date

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

Opt out of Paragon selecting site of care (if checked, please list site of care):

SERVICE AREAS

- Atlanta Austin Birmingham Dallas/Fort Worth Denham Springs Denver East Texas
- Houston Huntsville Kansas City Knoxville Montgomery Nashville Oklahoma City
- Orlando San Antonio St. Louis Tampa West Texas

PARAGONHEALTHCARE.COM

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COMPREHENSIVE SUPPORT FOR INFUSION THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
- Labs attached (if applicable)
- Diagnostics attached (if applicable)
- Medical necessity (if applicable): _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance

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