

NON - ONCOLOGY INFUSION REFERRAL FORM

Phone: 207-303-3225 Fax: 207-692-2473

Patient Name: First _____ m.i. _____ Last _____ DOB ____ / ____ / ____ SS# _____

Birth Sex*

- Male
 Female

Primary/Preferred Language:*

- Arabic
 Cambodian
 English
 French
 Russian
 Vietnamese
 Other _____

Race:*

- American Indian or Alaska Native
 Black or African American
 Native Hawaiian or Pacific Islander
 White/Caucasian
 Asian
 Prefer not to answer
 Do not know

Ethnicity:*

- Latino or Hispanic
 Not Latino or Hispanic
 Prefer not to answer

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ check if same

Phone number: Home: _____ Cell: _____

*Does this patient need an interpreter? Yes No If yes, what language? _____

Referring Office: _____ **Referring Provider:** _____

NPI#: _____ **Tax ID#:** _____

Contact Person: _____ Phone#: _____ Fax#: _____

Primary Care Provider: _____

Location preference

Is the patient in a skilled nursing facility? Yes No

Is the patient ambulatory? Yes No

If no, what are the patient's needs? _____

- Kennebunk
 Portsmouth
 Scarborough
 Topsham

Please fax this referral form and additional documents a minimum of 1 week prior to requested infusion date

Referrals must include the following:

- Patient Demographics
 Most recent office note (signed) with Height and Weight, LCD approved ICD-10 diagnosis code.
 Drug order form (signed and dated)
 Copy of insurance Prior Authorization with NECS as rendering provider/location

NECS NPI# 1205896107 Tax ID#010357684

- Copy of insurance card front & back, Rx card if applicable**
 Labs: CBC, CMP, and additional listed on drug order form
 Insurance: _____ **ID#** _____ **Group#** _____

(only needed if copy of card isn't obtainable)

Thank you for referring your patient to NECS Infusion Center!