



Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH

Non-Oncology Infusion Referral Form

Patient Name Middle Last DOB

Birth Sex: Male Female

Ethnicity: Latino or Hispanic Non Latino or Hispanic Prefer not to answer

Primary/Preferred Language: Arabic Cambodian English French Russian Vietnamese Other:

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

Physical Address City State Zip

Mailing Address (if different) City State Zip

Home Phone Cell Phone

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

Referring Office Referring Provider

NPI # Tax ID # Primary Care Provider

Contact Person Phone Fax

Is the patient in a skilled nursing facility? Yes No Is the patient ambulatory? Yes No

If no, what are the patient's needs?

Location Preference: Kennebunk Rock Row Topsham Portsmouth



Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH

Non-Oncology Infusion Referral Form

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)