

**GENERAL REFERRAL ENROLLMENT & PRESCRIPTION FORM**

**PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.usspecialtycare.com**

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

<b>PATIENT INFORMATION</b>	Patient: _____ Caregiver: _____
	DOB: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Weight: _____ <input type="checkbox"/> kgs or <input type="checkbox"/> lbs (check one) Height _____ <input type="checkbox"/> in or <input type="checkbox"/> cm (check one) Recorded Date: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Best Phone #: _____ <input type="checkbox"/> Cell Alternate Phone #: _____ <input type="checkbox"/> Cell Email: _____
	Allergies: _____ Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No
	ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

**PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION.  
PLEASE PROVIDE ALL **CLINICAL** INFORMATION INCLUDING LAB RESULTS ON ALL FORMS.**

<b>PRESCRIPTION INFORMATION</b>	<b>MEDICATION</b>	<b>DOSE/STRENGTH</b>	<b>DIRECTIONS</b>	<b>QUANTITY</b>	<b>REFILLS</b>
					DAW: _____
					DAW: _____
					DAW: _____
					DAW: _____
					DAW: _____
					DAW: _____

**INJECTION TRAINING:  OFFICE TO COORDINATE  USSC TO COORDINATE**

<b>PRESCRIBER INFORMATION</b>	Anticipated Start Date: _____ Prescriber Specialty: _____
	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Clinic <input type="checkbox"/> Other: _____
	Fax #: _____ Contact Name: _____
	Office Address: _____ City: _____ State: _____ Zip: _____
	The terms and conditions posted at <a href="http://www.usspecialtycare.com">www.usspecialtycare.com</a> have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at <a href="http://www.usspecialtycare.com">www.usspecialtycare.com</a> have been read by the person signing this form and are incorporated into this document by reference.
	<input type="checkbox"/> I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.
Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____	
<input type="checkbox"/> Use substitution <input type="checkbox"/> Dispense as Written	

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (800)-641-8475 to obtain instructions as to the proper destruction of the transmitted material.