# INFUSION SUITE


4875 Higbee Ave NW Canton Ohio 44718

Phone 330-492-3345 Fax 330-491-9758

**Patient Information**

First Name_____Last Name _____

DOB_____ □ M □ F Phone _____

Address_____

Diagnosis / ICD-10 □ J45.50 Severe persistent asthma, uncomplicated

□ J45.51 Severe persistent asthma with (acute) exacerbation

□ L50.1 Idiopathic Urticaria

| | Primary Insurance | Secondary insurance | Pharmacy Insurance |
|---|---|---|---|
| Insurance Provider | | | |
| Insurance Phone # | | | |
| Cardholder ( if not patient) | | | |
| Cardholder DOB | | | |
| Policy # | | | |
| Group # | | | |

**Doctor Information**

Name_____NPI_____

Address _____

Phone_____ Fax _____

Signature_____Date _____

*Prior Authorization and Verification of Benefits will be completed by our office.

*Please attach the 3 most recent MD notes, last 3 lab results, demographic sheet (including insurance information) and the completed order form. If any records are unavailable, please let us know.