Infusion Suite

Order Form

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 _____

Medication Requested /J-Code _____

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

Doctor Information

Name_____ NPI: _____

Prescriber Tax ID: _____ Group 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.