Print Clear Form

Oncology

Please fax to
866.279.3315

PATIENT INFORMATION

Clear Patient Information

Last Name _____ First Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Mobile Phone _____ E-mail _____

Social Security # _____ Date of Birth _____ Gender: ❑ Male ❑ Female

Primary Caregiver _____ Relation _____ Phone _____

Emergency Contact _____ Relation _____ Phone _____

INSURANCE INFORMATION (Please send a copy of the patient's insurance card, both front and back.)

Clear Insurance Information

1. Primary Insurance _____ ID # _____ Group # _____ Phone _____

Insured's Name _____ Insured's Employer _____ Relationship _____

2. Secondary Insurance _____ ID # _____ Group # _____ Phone _____

Insured's Name _____ Insured's Employer _____ Relationship _____

CLINICAL INFORMATION

Clear Clinical Information

********** ***Please send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Anuthorization Processing*** **********

ICD-/ . Code _____ Primary Diagnosis _____ Current Weight _____kg/lb Height _____inches/cm BSA_____m2

Allergies: ❑ Yes ❑ No If yes, please list _____

Therapy: ❑ New ❑ Restart Prior Therapies:

MEDICATION

Clear Medications Information

Drug Name	Dose/Strength	Directions	Quantity	Refills

SUPPORTIVE MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

Deliver To: ❑ Home ❑ Physician* **If shipped to physcian's office, physician accepts on behalf of patient for administration in office.*

Anaphylaxis Kit Needed: ❑ Yes ❑ No *If yes, please provide patient with a prescription for an EpiPen which he/she may pick up at their pharmacy of choice.*

PHYSICIAN INFORMATION

Clear Prescriber Information

Physician Name _____ Contact Name _____

NPI #_____ DEA # _____ Lic # _____ Tax ID# _____

Phone/Fax _____ E-mail _____

Address _____ City _____ State _____ Zip _____

I authorize to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer. I also certify that all the information above is correct to the best of my knowledge and the prescribed therapy is a medical necessity.

Physician Signature _____ _____ **Date**_____

Dispense as Written Substitution Permissible

Print