REFERRING OFFICE, ALSO FAX:

- Order
- Most recent labs
- Supporting clinical notes

Referral Checklist

Learn more at
https://www.ohioinfusionservices.com/for-providers/submit-a-referral

OIS Ohio Infusion Services

NOTE: When sending a referral, the Referral Checklist is not required. The information specified must be included, either on this form or on attached documentation. Ohio Infusion Services recommends using its therapy-specific order forms to accelerate prior authorization.

[ ] Patient Demographics

[ ] Patient demographics attached (If YES, you may skip the Patient Demographics section.)

Patient Name _____ DOB _____

Address _____ Email _____

City, State, Zip Code _____ Home Phone _____

Mobile Phone _____

Enrolled in Funded Program? _____ Yes _____ No _____ N/A

[ ] Patient is interested in patient support programs

[ ] Patient Insurance

[ ] Front and back of insurance card attached (If YES, you may skip the Patient Insurance section.)

Primary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Secondary Payer _____ Group # _____

Subscriber Name _____ ID # _____

[ ] Order, Diagnosis, and Clinical Information

[ ] Order, Diagnosis and Clinical Information attached

(Go to *https://www.ohioinfusionservices.com/for-providers/submit-a-referral* to download a therapy-specific order form and review the supporting clinicals.)

[ ] Contact Information*

[ ] Contact Information attached (If YES, you may skip the Contact Information section below.)

Contact Name Practice Name

Title

Phone Email

*Please list the contact information of the individual to reach if additional information is required to process the referral.

Please fax the order form to (440) 443-0700