Community Order

Infusion Therapy Center

DATE | OFFICE PHONE | OFFICE FAX

ORDERING PHYSICIAN

PATIENT LAST NAME | PATIENT FIRST NAME | MI

PATIENT DOB

Rx Script: _____

Number of Refills: _____

Primary ICD-10 Code: _____ **Secondary:** _____

PROVIDER NAME | PROVIDER SIGNATURE | DATE

Incomplete orders will be returned for correction. ICD 10 codes are necessary to ensure an authorization can be obtained for your patient.

Please include a copy of the following with your order:

- ☐ Patient demographics
- ☐ Insurance card(s)—front and back
- ☐ Recent office notes
- ☐ Recent labs

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