

**ADVANCED PHARMACY AND
RESPIRATORY CARE SOLUTIONS**



TODAY'S DATE: ___/___/___
REFERRED BY: _____
PHONE No. _____
FAX No. _____

ANY QUESTIONS CALL INTAKE: 800.464.7736
FAX FORM TO: 949.582.6111

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PRIMARY LANGUAGE: _____
SS#: _____ D.O.B.: _____ SEX: M _____ F _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ OTHER: _____
CAREGIVER EMERGENCY CONTACT PHONE: _____ RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION

<u>PRIMARY INSURANCE</u>	<u>SECONDARY INSURANCE</u>
SUBSCRIBER: _____	SUBSCRIBER: _____
ID#: _____	ID#: _____
GRP. POLICY: _____	GRP. POLICY: _____
PHONE: _____	PHONE: _____
EMPLOYER: _____	EMPLOYER: _____

STATEMENT OF MEDICAL NECESSITY: PRIMARY DIAGNOSIS

PRIMARY DIAGNOSIS: _____

DIAGNOSIS CODE: _____ DESCRIPTION: _____
DIAGNOSIS CODE: _____ DESCRIPTION: _____
OTHER MEDICAL HISTORY: _____ ALLERGIES: _____
HEIGHT: _____ WEIGHT: _____ AS OF DATE: _____

MEDICATIONS

MEDICATION: _____ STRENGTH: _____
SIG: _____
MEDICATION: _____ STRENGTH: _____
SIG: _____

TO BE ADMINISTERED: IN OFFICE CLINIC / OUT PATIENT FACILITY HOME OTHER

PHYSICIAN INFORMATION

Physician: _____ Physician's Phone #: _____
Physician's Address: _____
Office Contact: _____
Physician's NPI #: _____ California License# _____
Physician's Signature: _____ **M.D.** **DATE:** ___/___/___
CCS Panaleed Co-Signature (if perscribing MD not panaleed): _____

ADVANCED PHARMACY AND RESPIRATORY CARE SOLUTIONS
26611 CABOT ROAD SUITE B, LAGUNA HILLS, CA 92653