

Please note, failure to complete all of the fields on this form may result in delay of patient care.

PATIENT DEMOGRAPHICS				DATE REFERRAL SENT TO CARECENTRIX			
LAST NAME			FIRST NAME			DATE OF BIRTH	
STREET ADDRESS (WHERE SERVICES RECEIVED)(PO BOX NOT APPLICABLE)			CITY		STATE	ZIP	
PHONE # (WITH AREA CODE)			ALTERNATE PHONE #			GENDER	
REFERRAL/FACILITY INFORMATION				ADMISSION DATE		DISCHARGE DATE	FAX #
CONTACT NAME/FACILITY NAME			PHONE # (WITH AREA CODE)			PLACE OF SERVICE (Required for Florida Blue Sleep Diagnostics)	
AFTER HOURS CONTACT			AFTER HOURS CONTACT #			<input type="checkbox"/> 11 - office, clinic, freestanding lab independent clinic <input type="checkbox"/> 12 - home sleep test <input type="checkbox"/> 22 - hospital based lab	
INSURANCE INFORMATION				SUBSCRIBER ID #			
INSURANCE NAME			GROUP#		OTHER INSURANCE		Reminder auth Place of Service MUST match claim Place of Service to prevent claims denial issue.
SUBSCRIBER'S LAST NAME		SUBSCRIBER'S FIRST NAME		SUBSCRIBER'S DATE OF BIRTH		PATIENT'S RELATIONSHIP TO SUBSCRIBER	
CLINICAL INFORMATION				ATTACH ADDITIONAL CLINICAL INFORMATION TO SUPPORT REQUEST: - MD SIGNED ORDER/DISCHARGE ORDERS IF COMING FROM A FACILITY - HISTORY & PHYSICAL AND DISCHARGE SUMMARY - MD SIGNED LOMN-IF THIS IS A REQUIREMENT PER THE MEDICAL COVERAGE GUIDELINE - FOR PROVIDER REFERRALS-MD SIGNED PLAN OF CARE/HCFA 485 - NURSING OR THERAPY EVALUATION AND VISIT NOTES FOR EACH REQUESTED DISCIPLINE - WOUND ASSESSMENT/SPECIFIC WOUND CARE ORDERS/LIST OF WOUND CARE SUPPLIES - MOST RECENT SLEEP TEST			
PRIMARY DIAGNOSIS TO SUPPORT REQUESTED SERVICE(S)		OTHER SUPPORTING DIAGNOSIS		RECENT APPLICABLE PROCEDURE/SURGERY AND DATE			
HOMEBOUND STATUS (PLEASE CIRCLE THE SELECTION THAT BEST DESCRIBES PATIENT SITUATION) - PAIN WITH AMBULATION OF SHORT DISTANCES - BED BOUND - REFUSES TO LEAVE HOME DUE TO PSYCHIATRIC ILLNESS - SOB WITHOUT MINIMAL EXERTION - WHEELCHAIR BOUND AND UNABLE TO SIT FOR EXTENDED PERIODS OF TIME - UNABLE TO AMBULATE MORE THAN 100 FT WITHOUT RESTING - UNABLE TO LEAVE HOME BECAUSE UNABLE TO NEGOTIATE STAIRS - INFECTION; IMMUNE COMPROMISED DUE TO: _____ PLEASE EXPLAIN: _____							
SERVICE REQUESTS				ABLE AND WILLING CAREGIVER (NAME AND PHONE NUMBER)			
ALLERGIES				HEIGHT		WEIGHT	
				(REQUIRE D FOR INFUSION THE RA P Y AND A P P L I C A B L E H M E)			
FOR INFUSION ONLY:			TYPE OF ACCESS		NEXT DOSE DUE DATE/TIME	IS THIS A FIRST TIME DOSE? Y/N	
O2 SATURATION LEVEL	DURATION	LITER FLOW	ROUTE-IE: MASK, NASAL	DATE OF ORDER		START DATE (IF DIFFERENT THAN DATE OF ORDER)	
DETAILED DESCRIPTION OF ITEMS NEEDED FOR O2:						REQ SOC DATE RANGE	
HOMECARE ORDERS (PLEASE SPECIFY)						REQ SOC DATE RANGE	
BREAST FEEDING REQUESTS - WHAT IS THE PREFERRED BRAND			FL BLUE - HAS THE PATIENT REGISTERED FOR DELIVERY OR DELIVERED IN THE LAST 9 MONTHS?			DELIVERY DATE	
DELIVERY INFORMATION (IF DIFFERENT FROM ADDRESS ABOVE)							
PHYSICIAN INFORMATION				PRIMARY CARE PHYSICIAN NAME AND PHONE NUMBER			
ORDERING PHYSICIAN'S FIRST AND LAST NAME/TAX ID/NPI				FACILITY CONTACT INFORMATION:			
ORDERING PHYSICIAN PHONE #							
ADDITIONAL CLINICAL INFORMATION							