|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CORE CLINICAL CARE INTAKE SHEET** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insurance Update Only? YES / NO | | | | | | | | | | |  |  |  |  |  |  |  | If Yes, Effective Date: / / | | | | | | | | | | | | |  |  |  |  |  |  |  |
| Referral Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | | | | | | | | |  | Time: \_\_\_\_:\_\_\_\_ AM/PM | | | | | | | | Referral Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| Info Taken By: | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone #: ( ) | | | | | | |  |  |  | |  |  |  |  |  |  |  |
| Customer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Sex: M / F | | | |  | Marital Status: M /S /O | | | | | | | | |  |  |  |  |  |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Date of Birth: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ | | | | | | | | | | | | | |  |  |  |  |  |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Customer Phone: (\_\_\_\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  |
| City / State / Zip | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Cell Phone: | | | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |
| Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Lic. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Address: | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone: ( ) Fax: ( ) | | | | | | | | | | | | | | |  |  |  |  |  |
| Diagnosis/Operative Procedures: | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |  |
| Date of Diagnosis: / / | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |  |
| Other Pharmacies Providing Testing Supplies: | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |  |
| Name: | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone #: ( ) | | | | | |  | |  |  |  | |  |  |  |  |  |  |  |  |
| Primary Ins.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Insured's ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Eligability Date: Part A \_\_\_\_\_\_\_\_\_\_\_\_ Part B \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Ins. Phone #: ( \_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | Benefit/Eligibility Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IVR?: \_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |  |
| If Medicare: HMO? YES / NO | | | | | | | | | |  |  |  |  |  | Home Health Agency: YES / NO | | | | | | | | | |  | |  |  |  | |  |  |  |  |  |  |  |
| Use of Network Providers Required: YES / NO | | | | | | | | | | | | | |  | Insurance Pay Us Direct: YES / NO | | | | | | | | | | | |  |  |  | |  |  |  |  |  |  |  |
| Deductible: YES / NO | | | | | | |  | If Yes: $\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Remaining: $\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | Pymt After deductible: \_\_\_\_\_\_\_\_\_\_\_\_% | | | | | | | | | | | | | |
| Out-of-Pocket: $\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | Met: $\_\_\_\_\_\_\_\_\_ | | | | | | Remaining: $\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Pymt After OOP Met: \_\_\_\_\_\_\_\_\_\_\_\_\_% | | | | | | | | | | | | | |
| Auth Req: YES / NO | | | | | | |  | Auth #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Reference #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| Case Mgr: YES / NO | | | | | | | If Yes; Name: | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone #: ( ) | | | | | | | |  |  |  |  |  |
| Additional Notes: | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |

Community Pharmacy Foundation | GTwigg - Grant #143 | <http://www.communitypharmacyfoundation.org/grants/grants_list_details.asp?grants_id=70981>