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