



SPECIALTY MEDICATION AUTHORIZATION FORM: URGENT ROUTINE REFERRAL

To Be Completed By Physician's Office and Faxed To Maryland Physicians Care MPC at 866-207-7231

Supporting medical records and documentation such as chart notes, lab results and completing this form are required for processing your request. Incomplete information will result in a delay in processing your request. The information must be faxed to the number above within 3 business days or your request will be denied.

Last Name		First Name		Home Phone Number		Today's Date		Date Needed	
Parent / Guardian				Physician's Name (please print)				Hospital / Clinic	
Home Address		City		State		Zip		Address	
								City	
								State	
								Zip	
Shipping Address : Home <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/> (If address is different from home – please provide below)						Phone Number		Fax Number	
						Office Contact			

Primary Insurance Company Maryland Physician's Care MPC Fax #: 866-207-7231			Member ID #		Date of Birth		<input type="checkbox"/> Male or <input type="checkbox"/> Female	
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Medication: _____		Strength: _____		Quantity: _____		Refill x _____ month(s)	
Direction for Use: _____		Patient Ht. _____		Patient Wt. _____		Allergies: _____	
Physicians Signature _____				DEA/NPI: _____			

Primary Diagnosis: _____		ICD 9 Code: _____		CPT Code: _____		Estimated Start of Therapy: _____		Facility Name: _____	
Medical History:									

To Be Completed By Schaller Anderson and Faxed to Specialty Pharmacy for Processing:

Authorization Approved and Override Entered

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS