GENERAL PATIENT AUTHORIZATION

15 Earhart Drive, Suite 101, Amherst, NY 14221

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:
Date of birth: Sex: Weight:	Prescriber: Specialty:
Home Phone Number: ( )	Phone Number: ( ) Fax Number: ( )
Home Address: City: State: Zip:	Address: City: State: Zip:
Allergies:	Notes:

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: Independent Health

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

Secondary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD 10 Code: _____

Please list or attach documentation listing previous treatments tried and failed:

Medication Name	Therapy Dates	Results

Requested Drug Name: _____

Dose: _____

Frequency: _____

Administration: ☐ Self-administered ☐ Other: _____

Expected duration of therapy: _____