

# ENTYVIO® Referral Form

**Fax completed form to: 833-871-9247**

7307 South Revere Parkway, Suite 201 | Centennial, CO 80112 | Phone (720) 456-3989



Patient Information			
Patient Name:	Date of Birth:	Male:	Female:
Address:	City:	State:	Zip:
Home Phone:	Other Phone:		
Height:	Weight:	Allergies:	
Insurance Information			
<b>Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)</b>			
Other Documentation			
<b>Notes:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____		<b>Please attach:</b>  Patient demographics  Rx with premeds if required  Rx for anaphylaxis  Rx for flushes  Most recent clinical notes  Most recent TB test  Prior medications tried and failed and dates  Lab orders	
Physician Information			
Physician Name:	Lic.#:	DEA #:	
Practice Name:	NPI #:	Specialty:	
Address:	City:	State:	Zip:
Nurse Contact:	Phone:	Fax:	
Physician Signature:			Date:
<p>By signing this form and utilizing our services, you are authorizing Mosaic and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</p> <p><b>Important Notice:</b> This transmission may contain confidential health information that is legally protected. As you are obligated to maintain it in a safe and confidential manner, unauthorized re-disclosure or a failure to maintain confidentiality of the information contained herein could subject you to penalties under state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination or copying of this communication is strictly prohibited.</p>			

**Please include all lab results and list of concurrent medications.**