

General Referral Form

Fax completed form to: 833-871-9247

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



Insurance Information

Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)

Diagnosis and Statement of Medical Necessity

Diagnosis:

Prescription Information

all supplies including syringes and needles will be dispensed if needed

Medication	Dose/Strength	Route	Directions	Quantity	Refill

Anaphylaxis Kit

EpiPen 0.3mg IM 2-pak - Use as Directed OR EpiPen Jr. 0.15mg IM 2-pak - Use as Directed
 Epinephrine vial 1:1000 IM x1 dose
 Diphenhydramine 50mg po x2 doses OR Diphenhydramine ____mg IM x1 dose
 Acetaminophen 500mg po x 1 dose

Additional Instructions

Skilled Nursing visits as required? Yes No Ship to: Patient Physician Other : _____

Standard supplies as needed Lab orders: _____

Physician Information

Physician Name:	Lic. #:	DEA #:
Practice Name:	NPI #:	Specialty:
Address:	City:	State: Zip:
Nurse Contact:	Phone:	Fax:

Physician Signature: _____

Date: _____

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.

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Please include all lab results and list of concurrent medications.