REMICADE® Referral Form

Fax completed form to: 833-871-9247

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

mosaic infusion solutions

Patient Information			
Patient Name:	Date of Birth:	Male: Female:	
Address:	City:	State:	Zip:
Home Phone:	Other Phone:		
Height:	Weight:	Allergies:	

Insurance Information

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

Other Documentation

Notes: _____

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Please attach:

- 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:	

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.

Important Notice: 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.

Please include all lab results and list of concurrent medications.

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