St. Mary's Healthcare Amsterdam
Infusion Center
4950 State Highway 30, 1st Floor
Amsterdam, NY 12010
Phone 518-770-7557 Fax 518-841-3671

Infusion Center Order Form

Name _____
DOB _____
Phone _____
SMH MR# _____ (office use only)

Allergies (reactions): _____ Ht:_____in. Wt:_____kg.

Medication and Administration Orders

Medication: _____ Dose: _____

Route: _____ Frequency: _____

Pre-medications or additional instructions:

_____

_____

_____

Prescriber Name: _____ NYS License #_____ DEA #_____

Prescriber Signature: _____ Date Ordered: ____/____/_____

Office Contact Name & Phone Number: _____

Prior Authorization

Diagnosis/Reason for Administration: _____ J-code: _____

Prior authorization must be obtained from patient's **MEDICAL BENEFITS**. Identify St Mary's Healthcare Infusion Center as location of administration. If patient has secondary insurance, authorization must be obtained from both carriers.

☐ **YES, PRIOR AUTHORIZATION REQUIRED**

PRIOR AUTHORIZATION #: _____ DATE RANGE: _____ to _____

➢➢➢ **PROOF OF APPROVAL - ATTACH COPY OF PRIOR AUTHORIZATION LETTER/DOCUMENTATION** ➣➣➣

☐ **NO PRIOR AUTHORIZATION REQUIRED**

CALL REF # _____ INSURANCE & REP NAME_____

This referral/agreement, per HRSA guidelines is between the ordering prescriber and St. Mary's Healthcare Infusion Center to perform infusion services on the referred individual listed above. This form should be used for orders of medications administered by injection or infusion to patients at the St. Mary's Healthcare Infusion Center. This order must be signed by a licensed independent practitioner. This order is valid until expiration of authorization, 12 months from signature date, or as specified by prescriber, whichever is sooner. Prior authorization must originate from prescriber's office.

Failure to complete or sign this form will delay scheduling of any treatment.