CAREMARK It all starts with care®

Please fax completed form to Caremark at (800) 323-2445.
To order by phone, call CaremarkConnect toll-free
(800) 237-2767.

HUMANA Guidance when you need it most

The prescription has been electronically transmitted or faxed by:_____
(Faxing Agents Full Name)

Patient Referral Form

Physician Information

Physician's Name:

Address:

City: State: Zip:

Office Contact:

Telephone: Fax:

State License #:

DEA #: UPIN#:

Patient Information

Patient's Name:

Address:

City: State: Zip:

Date of Birth: Sex: ☐ M ☐ F

Patient ID #:

Daytime Telephone #: Evening Telephone #:

Emergency Contact & Relation: Contacts Telephone#:

Primary Insurance Information

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Insured Date of Birth:

Subscriber ID #:

Group ID #:

Relationship Code / Relationship to Insured:

Secondary Insurance Information

Insurance Company:

Insured's Name:

Alternate ID #: Date of Birth:

Subscriber ID #:

Group ID #:

Relationship Code / Relationship to Insured:

Prescription Medication Strength

1)

2)

3)

Refills: Physician's Signature:

Directions (Dose/Route/Frequency) Quantity/Length

Date of Prescription: DAW:

Additional Patient Information

Primary Diagnosis:

Secondary Diagnosis:

HCPC Code:

Height: Weight:

ICD9 Diagnosis Code:

ICD9 Diagnosis Code:

CPT Code:

Allergies:

Shipping Information

Ship to: ☐ Physician

☐ Patient's Home

☐ Other (Enter address information at right →)

Target Delivery Date: Refill Date:

If You Selected Other:

Address:

City: State: Zip:

Area Code and Phone: