



SPECIALTY MEDICATION AUTHORIZATION FORM: URGENT ROUTINE REFERRAL

To Be Completed by Physician's Office and Faxed to Delaware Physician's Care, Incorporated at 877-861-2611: Supporting medical records and documentation as well as completing this form are required for processing your request. Incomplete information will result in a delay of processing your request. The information must be faxed to the number above within 3 business days or your request will be denied.

Today's Date: _____

Member Information:

Provider Information:

Last Name		First Name		Physician's Name (please print)		Pay To/Group Name	
ID Number	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female		Shipping Address		City	State
Home Address		City	State	Zip	Phone Number		Fax Number
Date Medication Needed:				Office Contact:			

If the member has Primary Insurance, other than DPCI, please complete:

Primary Insurance Company Schaller Anderson - ESI Delaware Physician Care (DIV DSA)	Member ID #:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Medication Information:

Medication:	Strength:	Quantity:	Refill x _____ month(s)
Directon for Use:	Patient Ht:	Patient Wt:	Allergies:
Physician's Signature:		UPIN #/DEA:	
Primary Diagnosis:	ICD 9 Code:	Est Start of Therapy:	
Medical History			

To Be Completed By Schaller Anderson and Faxed to Curascript for Processing: _____

Authorization Approved and Override Entered

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS