

Specialty Pharmacy Paragard Referral Form

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____ / _____ / _____

☐ See Attached Demographic Sheet

PRESCRIBER INFORMATION

Physician Name: _____

State Lic #: _____

NPI #: _____ Specialty: _____

Practice Name/Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Phone: _____

Physician's Fax: _____

Nurse/Key Office Contact: _____

PREFERRED COMMUNICATION

Direct Phone Number: _____

Direct Email Address: _____

INSURANCE INFORMATION (Please attach copies of front & back of cards)

Primary Insurance:	Secondary Insurance:	Rx Card (PRM):
City: _____ State: _____	City: _____ State: _____	PBM BIN: _____
Plan #: _____	Plan #: _____	City: _____ State: _____
Group #: _____	Group #: _____	Group #: _____
Phone: _____	Phone: _____	Phone: _____

Cardholder First Name: _____ Last Name: _____

Employer: _____ ID #: _____ Group #: _____

PRESCRIPTION INFORMATION

☒ **PAR T380A – QTY 1/Paragard Non-Hormonal Copper Intrauterine Device**

DIAGNOSTIC INFORMATION (ICD-10 Code)

☒ **Z30.430:** Encounter for insertion of intrauterine contraceptive device

☐ **Other:** Please Specify: _____

Patient's Signature _____ Date _____ / _____ / _____

Physician's Signature _____ Date _____ / _____ / _____

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