

**UNIVERSAL REFERRAL FORM**

**SUPERIOR BIOLOGICS**  
**Fax Referral To: 914-747-1170**  
**Phone: 855-747-1150**



Date: \_\_\_\_\_

Needs by Date: \_\_\_\_\_ Ship to  Patient's Home  Prescriber 1<sup>st</sup> Order Only  Prescriber All Orders**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender:  M  F

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID#: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Group: \_\_\_\_\_

**DIAGNOSIS & LABWORK (Fill in below or attach lab work)**

Primary Diagnosis: \_\_\_\_\_ Therapy:  New to Therapy  Currently on Therapy, Start Date: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication	Form	Strength	Quantity	Dose	Refills	Directions

Other/Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ DAW (Dispense as Written) Date: \_\_\_\_\_

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