



LDI SPECIALTY PHARMACY REFERRAL

Phone: (866)516-4121 or local (314)652-4126

Fax: (314)652-4126

Today's Date: _____

Referral Contact: _____

Phone: _____

A. EMPLOYEE / PAYER INFORMATION:		B. PATIENT / EMPLOYEE INFORMATION:		
Employer Name:		Patient Name:		
Payer Name:		Patient ID #:	DOB:	Gender:
Claims Mailing Address:		Relationship to Employee:		
Payer Primary Contact:		Patient Address:		
Phone Number: ()	Fax Number: ()	Employee Name:		
Email Address:		Employee ID #:	DOB:	Employee Phone: ()
Current Stop Loss Carrier:		Employee Address (if different from patient):		
Stop Loss Contract Basis:		Primary Payer:	Effective Date of Coverage:	
Plan Year:		Secondary Payer (if applicable):	Effective Date of Coverage:	

C. MEDICAL INFORMATION:			
Prescribing Physician Name:	Phone Number: ()	Medication Ship to:	Medication Needed by:
Diagnosis:	Dosage:	Frequency:	ICD-9 Code:
Name of Specialty Drug Prescribed:	Is Pre-certification # required to process this claim? <input type="checkbox"/> Yes, # _____ <input type="checkbox"/> No		Current Cost:

ALL MAJOR MEDICAL BENEFITS ARE CONSIDERED AT THE PREFERRED PROVIDER BENEFIT LEVEL

Patient Copay / Co-Insurance is based on information below:

SELF-INJECTABLE BENEFIT:	PHYSICIAN ADMINISTERED INJECTABLE OR INFUSION BENEFIT:
Covered as: <input type="checkbox"/> Major Medical <input type="checkbox"/> Rx Co-payment If Rx Co-payment, copay amount for 30 day supply _____ If Major Medical, _____ Individual Calendar Year PPO Deductible _____ PPO Coinsurance Percentage Level _____ PPO Out of Pocket/deductible included <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Lifetime Maximum Benefit Benefits based on: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year If Plan Year please advise starting month _____ Satisfied Calendar Year deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No Reached annual out of pocket maximum? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Major Medical, _____ Individual Calendar Year PPO Deductible _____ PPO Coinsurance Percentage Level _____ Maximum Calendar Year Out of Pocket _____ Lifetime Maximum Benefit Benefits based on: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year If Plan Year please advise starting month _____ Satisfied Calendar Year deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No Reached annual out of pocket maximum? <input type="checkbox"/> Yes <input type="checkbox"/> No

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