Provider Fax Form

Date: _____ **Sent Via Facsimile**

Please complete the form below and submit all clinical information via fax at 215-784-0672.

Patient Name: _____ Patient Phone #: _____

Patient Date of Birth: _____ Patient Agreement #: _____

Is AmeriHealth Administrators your Primary Insurance? _____

Requestor's Name: _____ Requestor's Telephone #: _____

Requestor's Fax #: _____

Facility/Servicing Provider Name: _____

Facility/Servicing Provider Address: _____

Facility/Servicing Provider NPI#: _____

Attending/Ordering Physician Name: _____

Attending/Ordering Physician Address: _____

Attending/Ordering Physician NPI#: _____

Admission/Service Date: _____

Requested Number of Units/Days: _____

Is Request Inpatient, Outpatient or Other: _____

If Outpatient, place of service (please circle one):

office, hospital outpatient, free-standing clinic, OR home infusion

Diagnosis Code(s): _____

Procedure Code(s): _____

Dose and frequency of drug, include weight in kg, if applicable: _____

Anticipated Discharge Needs, if applicable: _____

Clinical Information Required: **MUST SUBMIT CLINICAL INFORMATION**

Thank You,

Signature: _____ Date: _____

AmeriHealth Administrators

AmeriHealth Administrators
P.O. Box 21545 | Eagan, MN 55121
Fax #215-784-0672