DeKalb Medical
Tax ID Number 58-1966795

PS-1042

**Ambulatory Infusion Center Order Form**
FAX orders to: 404.501.7052
Phone: 404.501.6180

## Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

## Order Information - Ambulatory Infusion Center

Diagnoses: _____

ICD CM Codes: _____

Treatment: _____

CPT and/or HCPCS Codes: _____ Treatment Date: _____

**PHYSICIAN ORDERS:**

**RECURRING ORDER:** ❑ **EXPIRES:** _____
*(Check if YES)* *6 months from start date*

*You may attach additional orders to this form. Please do **NOT** attach a prescription pad page.*

## Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

**I hereby certify that the services indicated in the above order form are medically necessary.**

**Physician Signature:** _____ **Date:** _____ **Time:** _____