Patient Enrollment Form

Phone: (844)44-AXIVA
Fax: (844)440-0101

☐Havertown
☐Huntingdon Valley
☐Home
☐No Preference

Patient Information

Patient Name: _____
DOB: _____ ☐Male ☐Female
Address: _____
City: _____ State: _____ Zip: _____
Height: _____ Weight: _____ ☐ Lbs ☐ Kg
Allergies: _____
_____
Emergency contact: _____ Relationship: _____ Phone: _____

Insurance Information (attach copy of cards, if available)

Primary Insurance: _____
Member #: _____ Group#: _____
Policy Holder: _____ Relation: _____
Secondary Insurance: _____
Member #: _____ Group#: _____
Policy Holder: _____ Relation: _____
Rx Drug Card: _____
Prescription Drug Coverage: _____
Payer: _____ Bin & PCN: _____
Patient ID: _____ Group #: _____

Clinical Information

Diagnosis: _____
Drug: _____ First Dose: ☐Yes ☒No Next Infusion date: _____
Orders: ☒Will Send ☒Attached
_____
_____

Prescribing Physician

Name: _____ Office Contact: _____
Practice: _____ Specialty: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ NPI: _____ License #: _____ UPIN: _____

By signing below, physician certifies that the above therapy, products, and services are medically necessary, and the patient is under his/her care. Physician agrees to cooperate with Axiva Health Solutions to provide all necessary documentation for submission to patient's third-party payer. (Physician attests this is his/her legal signature. NO STAMPS)

Signature: _____ Date: _____