Case Referral Form

Today's Date _____

Referring Party / Contact _____

Phone / Fax _____ E-mail: _____

Company _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

SSN _____ DOB _____ **ESRD Date** _____

City _____ ST _____ Zip _____

Specialty Pharmacy Only Diagnosis _____

Drugs/Meds (J-Codes) _____

INSURANCE INFORMATION **Patient Plan Year:** _____

Employer Group Name _____ Group # _____

In/Out of Network _____ Network/PPO & Discount _____

Policy Type _____ **COBRA POLICY?** _____ **Effective Date** _____

Benefits & Amount Met: CoPay: _____ Deductible: _____ OOP: _____

MGU _____ Plan Year _____

Stop Loss _____ Plan Year _____

Payer _____ Plan Year _____

TPA/Contact _____ Phone/E-mail _____

Case Manager _____ Phone/E-mail _____

PROVIDER & CLAIMS INFORMATION **TAX ID #** _____

Provider _____

City _____ State _____ Zip _____

Contact _____ Phone _____ Fax _____

Charges Outstanding _____ Age of claims? _____

Send Worksheets/Invoice to (name, address, fax & email): _____

Include unpaid claims and current discount. Did you check plan benefits and PPO/PBM restrictions?

PO Box 272, Arrington, TN 37014 USA gtspecnet.com

Submit Referral to claims@gtspecnet.com or fax (615) 712-6831