Specialty Pharmacy Case Referral Form

Golden Triangle
A Specialty Network

REFERRING PARTY

Referral Date

Name & Company

Phone

Email

Fax

PATIENT INFORMATION

Full Name

Male

Female

DOB

Address

City

ST

Zip

Phone

Alternate

Previous Treatment Date

Next Treatment

Drug/Dose

Price $

Drug/Dose

Price $

Drug/Dose

Price $

Drug/Dose

Price $

Drug/Dose

Price $

Diagnosis

Additional Clinical Notes

INSURANCE INFORMATION

Group Name

Insured ID

Plan Administrator

Phone/Email

Stop-Loss/MGU

Phone/Email

Case Manager

Phone/Email

Network/PPO

Patient Plan Year

PROVIDER INFORMATION

Check if Out of Network

Provider/Facility

Prescriber/MD

Plan Administrator

City

ST

Zip

Address

Phone/Fax

Contact

Phone/Fax

Contact

Phone/Fax

Additional Notes

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