

Referral Form Checklist

To ensure the best possible insurance coverage, please provide:

- Completed and signed prescription referral form
- A copy of patient's insurance card and demographic information
- Copy of patient's most recent clinical notes



Fax

Complete referral form checklist and **provide required insurance and clinicals.**

Fax to:
877-892-4007

Required: Sending this documentation will ensure all insurance requirements are met



e-Prescribe

Send e-Scripts to:
GabeCare DirectRx
d/b/a DirectRx Pharmacy
830 Kirts Blvd. Suite 300
Troy, MI 48084
NPI: 1194725705

Tip: DirectRx can be found via a general pharmacy search by zip-code (48084)

Please remind the patient that DirectRx will be contacting them to schedule their medication delivery.

(P) 855-362-3397



Provide to
Patient

Your prescription will be processed by DirectRx Pharmacy.

Here is what you can expect next:

- A personalized Welcome Call
- Complete review of your insurance
- Free and convenient delivery
- On-going care and support

A member of our team will be contacting you shortly.

Please scan the QR Code to add DirectRx's
phone number, (855) 362-3397, to your
contact list.



(855) 362 - 3397 | info@directrx.com

Compassionate Connections. Successful Outcomes. Healthy, Happy Patients.

www.directrx.com



Su receta será procesada por DirectRx Pharmacy.

Esto es lo que puede esperar de nosotros en el futuro:

- Una llamada de bienvenida personalizada
- Revisión completa de su seguro medico
- Entrega gratuita y cómoda
- Atención y apoyo continuos

Un miembro de nuestro equipo se comunicará con usted muy pronto.

**Escanee el código QR para agregar el número
de teléfono de DirectRx, (855) 362-3397,
a su lista de contactos.**



Patient Information

Name	Date of Birth	Home Phone Number	Other Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient SS# [Recommended]	<input type="checkbox"/> Allergies <input type="text"/>		<input type="checkbox"/> No Known Allergies
<input type="text"/>			

Drug Delivery Info

Date Shipment Needed:

Doctor/Prescriber Info [NPI # is mandatory.]

Name	Office Contact		
<input type="text"/>	<input type="text"/>		
Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NPI #	Phone #	Fax #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email Address: <input type="text"/>			

Statement of Medical Necessity ** Please Fax recent clinical notes, tests with the prescription.

Medication	Dose/Strength	Sig	Qty	Refills

Doctor/Prescriber Signature

Date

Federally approved, generic equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician or health plan. I authorize DirectRx, Inc and it's representatives to act as an agent to initiate & execute the insurance prior authorization and any future fills of the same prescription for the patient listed above. I understand that I may revoke this right at any time by providing written notice to DirectRx, Inc.

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