Referral Form

Matrix Health Group
A BioMatrix Company

Email to: **INTAKE@matrixhealthgroup.com**
or Fax to: **1-888-385-2805**

Today's Date _____ Referred by _____

Please note: This is not a guarantee of coverage; additional information is required prior to start of service.

Patient Information:

Last Name _____ First Name _____ MI _____

DOB _____ Minor? Yes No

Address _____ Phone _____

City _____ Alt. Phone _____

State _____ Zip Code _____ Email Address _____

Clinical Information: Additional clinical information required prior to shipping medications

Diagnosis _____ Severity Mild Moderate Severe Inhibitor

Product _____ Dose _____ Shipment needed by _____

Referring Physician _____ Phone _____ State _____

Insurance Information: Attach copies of insurance cards (front and back)

Name of Insured _____ DOB _____ Relationship to Patient _____

Insured's Employer _____ Employer Phone _____

Primary Insurance _____ Ins. Phone _____

Member ID _____ RX Phone _____

RX Drug Plan _____ Group # _____

RX ID (If not the same as above) _____ Group # _____

Bin # _____ PCN # _____

Medicare # _____ Medicaid ID # _____ State _____

Secondary Insurance, if applicable:

Name of Insured _____ DOB _____ Relationship to Patient _____

Insure's Employer _____ Employer Phone _____

Primary Insurance _____ Ins. Phone _____

Member ID _____ RX Phone _____

RX Drug Plan _____ Group # _____

RX ID (If not the same as above) _____ Group # _____

Bin # _____ PCN # _____

Medicare # _____ Medicaid ID # _____ State _____

Matrix Health Group • 3300 Corporate Avenue, Suite 104 • Weston, Florida 33331. Phone: 954-385-7322 Toll Free: 877-337-3002 Pharmacy Fax: 888-385-2805