



Recast Referral Form

Patient Name _____ DOB _____

Address _____ Phone _____

- Diagnosis:
- ☐ Osteoporosis (M 81.0)
 - ☐ Osteopenia (M 89.9)
 - ☐ Pager's disease (M88.0)
 - ☐ Glucocorticoid-induced Osteoporosis - Treatment (M81.8 + Z79.51)
 - ☐ Glucocorticoid-induced Osteoporosis - Prevention ____ * {primary dx} + Z79.51
- (*Please provide the diagnosis code for the disease for which the patient is being treated.)

Referring Physician _____

Primary Insurance

Company _____

ID# _____ Group# _____

Cardholder Name _____

If patient is not cardholder, relationship? _____

Secondary Insurance (if applicable)

Company _____

ID# _____ Group# _____

Cardholder Name _____

If patient is not cardholder, relationship? _____



Reclast Infusion Center Information

- Referrals are accepted from physicians via Gabrail Cancer Center Referral Forms or by calling the office
 - Appointments can be scheduled by either the physician's office staff or patient
 - Patients can be scheduled within 3 days of the referral
 - Gabrail Cancer Center accepts Medicare Part B and most insurances
 - Gabrail Cancer Center staff will obtain all pre-certifications and prior authorizations from insurance companies
 - Gabrail Cancer Center will fax documentation to the referring physician upon completion of the infusion
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If you prefer to fax the referral, please include the following:

- Demographic page (including insurance information)
 - Completed referral page
 - Lab results (including Vitamin D level)
 - Last 2 visit notes
 - Current medication list
 - Bone Density Report
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We will call the patient to schedule the appointment once we obtain the authorization from the patient's insurance.