Optum Fax Cover Sheet

Patient's Name:	Sex (circle):	Date of Birth:	Insurance ID #:
Shipping Address:			Phone Number:
City:	State:	Zip:	Alternate Phone Number:

Drug Allergies: ☐ **None Known** ☐ Others: ______

☐ Penicillin ☐ Cephalosporins ☐ Ampicillin
☐ Sulfa ☐ Erythromycin ☐ Aspirin
☐ Codeine ☐ Tetracycline ☐ Quinolones

______

Health Conditions: ☐ High Blood Pres. ☐ Others: ______

☐ Diabetes ☐ Arthritis ☐ High Cholesterol
☐ Glaucoma ☐ Asthma ☐ Thyroid Disorder
☐ Osteoporosis ☐ Cancer ☐ Heart Condition

______

Medication & Strength:

Directions:

Qty

Refills: ☐ **0** ☐ **1** ☐ **2** ☐ **3** **Other:** ______

Brand Only: ☐ **YES**

Medication & Strength:

Directions:

Qty

Refills: ☐ **0** ☐ **1** ☐ **2** ☐ **3** **Other:** ______

Brand Only: ☐ **YES**

Medication & Strength:

Directions:

Qty

Refills: ☐ **0** ☐ **1** ☐ **2** ☐ **3** **Other:** ______

Brand Only: ☐ **YES**

Medication & Strength:

Directions:

Qty

Refills: ☐ **0** ☐ **1** ☐ **2** ☐ **3** **Other:** ______

Brand Only: ☐ **YES**

Physician's Name:		NPI:	DEA:
Street:			
City:		State:	Zip:
Phone:	Fax:		
Signature:		Date:	