JORDAN RESES PATIENT REFERRAL FORM

Please FAX this Completed Form to Jordan Reses Pharmacy:

FAX# 215-729-1040
or **800-838-3971**

To: **JORDAN RESES PHARMACY**
5739 Chester Avenue
Philadelphia, PA 19143
PHONE: 800-848-4050

From: **Name:**____ **Date:** ____ /____ /______

Address: ____

Phone: (_______) _________________________ **Fax:** (_______) ___________________________

CLAIMANT INFORMATION

Last Name: _______________________________ **First Name:** ______________________ **MI:** ________

SSN: _______ / _____ / _________ **Home Phone:** (_____) _______________

Date Of Birth: _____ /_____ /______ **(MO / DAY / YR)**

Address: ____

City: ____________________________________ **State:** ______ **Zip:** ____________

CLAIM INFORMATION

Employer: ________________________________ **Claim Number:** ___________________________________

Line Of Business: __________________________ **Date Of Injury:** _____ /_____ /______ **(MO / DAY / YR)**

If Auto/PIP Claim

Copay: ☐ Yes ☐ No **Amount:** __________ **Deductible Remaining:** _____________________________

INSURANCE INFORMATION

Insurance Company: ____

Billing Address: ____

City: ____________________________________ **State:** ______ **Zip:** ____________

ADJUSTER INFORMATION

Last Name: ___________________________________ **First Name:** __________________________________

Work Phone: (______) ____________________ **Company:** ____________________________________

E-Mail: _______________________________________

REFERRAL INFORMATION

Last Name: ___________________________________ **First Name:** __________________________________

Work Phone: (______) ____________________ **Company:** ____________________________________

E-Mail: _______________________________________

MEDICAL INFORMATION

Authorized Medications: ____

Would you like to create an Authorized Physician's List? If yes, please include Dr. name and DEA Number.

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