

Provider Communication

To: Fax: Date: 6/2/2016  
From: Tony , CPhT Fax: (503) 215-8455

We are contacting you in regards to patient: , (DOB):

Urgent  For communication only  Please reply

Acknowledgement of prescription receipt or receipt of referral.

We have received the following prescription/referrals:

Medication name: Medication name:  
Medication name: Medication name:

Credena Health is ABLE to fill the medication but the following information or processes must be completed before medication can be filled.

- Prior authorization needed. Please send the following information
  - Chart notes (most recent, supporting use of above therapy)
  - Patient face sheet including insurance information
  - Other:
- Co-pay or other financial assistance is needed. We are working with the patient and various resources to assist with co-pay.
- Other information needed. Please send the following information:
  - Active medication and allergy list
  - Other:

Credena Health is UNABLE to fill the medication due to:

- Access to the medication  Non-contracted insurance  Prior Authorization Denied
- The prescriptions have been transferred to: Phone: Fax:  
The patient was notified of this transfer on: Date:

The patient has been successfully contacted for REFILL of the following medication(s).

Medication name: Medication name:  
Medication name:  Other  
 Refill has been set up for the following Date:

The patient has NOT been successfully contacted for REFILL.

Please contact Credena Health to advise how to proceed.

OTHER:

- NEW prescription for:
- Other:

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