CredenaHealth

6348 NE Halsey Street, Suite A; Portland, OR 97213
Phone: 503-962-1700; Fax: 503-215-8455

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: