



**Provider Fax Form**

Date: \_\_\_\_\_

Sent Via Facsimile

**Please complete the form below and submit all clinical information via fax at 215-784-0672.**

Patient Name: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Patient Agreement #: \_\_\_\_\_

Is AmeriHealth Administrators your Primary Insurance? \_\_\_\_\_

Requestor's Name: \_\_\_\_\_ Requestor's Telephone #: \_\_\_\_\_

Requestor's Fax #: \_\_\_\_\_

Facility/Servicing Provider Name: \_\_\_\_\_

Facility/Servicing Provider Address: \_\_\_\_\_

Facility/Servicing Provider NPI#: \_\_\_\_\_

Attending/Ordering Physician Name: \_\_\_\_\_

Attending/Ordering Physician Address: \_\_\_\_\_

Attending/Ordering Physician NPI#: \_\_\_\_\_

Admission/Service Date: \_\_\_\_\_

Requested Number of Units/Days: \_\_\_\_\_

Is Request Inpatient, Outpatient or Other: \_\_\_\_\_

If Outpatient, place of service (please circle one):

office, hospital outpatient, free-standing clinic, OR home infusion

Diagnosis Code(s): \_\_\_\_\_

Procedure Code(s): \_\_\_\_\_

Dose and frequency of drug, include weight in kg, if applicable: \_\_\_\_\_

Anticipated Discharge Needs, if applicable: \_\_\_\_\_

Clinical Information Required: **MUST SUBMIT CLINICAL INFORMATION**

Thank You,

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

AmeriHealth Administrators

AmeriHealth Administrators  
P.O. Box 21545 | Eagan, MN 55121  
Fax #215-784-0672