

Albumin Enrollment Form

Patient Information

Last Name		First Name		MI			
Street Address		City		State		Zip Code	
Phone (daytime)		Phone (cell)		Date of Birth		Sex	

Primary Insurance Information Secondary Insurance Information Pharmacy Insurance Card

Insurance Name		Insurance Name		Insurance Name					
Cardholder Name		SSN		Cardholder Name		SSN		Member ID	
Group / Policy Number		Group / Policy Number		BIN Number		Group Number			

Physician Information

Physician Name:			Contact Person				
Street Address		City		State		Zip Code	
Physician DEA Number		Phone Number		Fax Number			

Statement of Medical Necessity : PLEASE INCLUDE A COPY OF CHART DOCUMENTATION OF DIAGNOSIS CODES

- Volume depletion associated with a Paracentesis ICD-9 Code: _____
- Ascites ICD-9 Code: 789.59 Cirrhosis ICD-9 Code: 571.5
- Hypoalbuminemia ICD-9 Code: 273.8
- Other (Please describe) _____ ICD-9 Code: _____
- Secondary diagnostic coding: _____ _____

Medical History : Please send copy of pertinent hx as needed:

Lab Draw Orders prn _____

Prescription Orders

Albumin 25% - 25gm / 100 mL: Dispense # _____ vials with appropriate infusion supplies
 Dispense as written Substitution allowed
 Infuse via Peripheral PICC Port Other _____ Access over _____ hour(s) every _____
Albumin Refills: _____
Premeds: Diuretic: _____ _____ mg IVP or PO Sig: _____ Other _____
Premed Refills _____ times Dispense as written Substitution allowed
Allergies: _____

Physician's signature _____

Date _____

Fax completed from to (214) 887-0436.

Insurance / Clearance Questions call (214) 276-5642 or mike.ellis@ntisp.org. For Pharmacy / Clinical questions call (214) 276-5623. Include following: Patient's insurance cards (front and back), lab work, letter of medical necessity, Pharmacy Benefit Card and any other documentation supporting the use of Albumin.

Patient's Preferred Infusion Center Location: Downtown Dallas NorthPark