

Spiro PD 2.0 Referral Form



Phone: 877-385-0535 Fax: 877-326-2856

Patient Demographics	Provider Information
Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F DOB: _____ SS#: _____ Phone: _____ 2 nd Phone: _____ Email: _____ Address: _____ City: _____ State: _____ Zip: _____ Primary language, if other than English: _____	Prescriber: _____ Phone: _____ Fax: _____ Facility/Clinic Name: _____ Address: _____ NPI: _____ Office contact: _____ Training by: <input type="checkbox"/> Prescriber's office <input type="checkbox"/> PMD Healthcare <input type="checkbox"/> Not needed
Authorized alternate contact information Name/relation: _____ Phone: _____ Email: _____	
Please fax a copy (front and back) of the patient's insurance card(s) as well as any relevant clinical notes/documents	

Clinical Information	Clinical Support*
Diagnosis: _____ ICD-10 Code: _____ Clinical Information/Comments: _____ _____ _____	<input type="checkbox"/> Patient to be enrolled in OptiMed's monitoring services and specialty pharmacy medication management*

Device(s) Ordered
<input type="checkbox"/> Spiro PD 2.0 Personal Spirometer – personal digital spirometer, mouthpiece, stand, and charging cord (Quantity #1)

*Clinical support service includes monitoring of lung function through the PMD portal in conjunction with the provision of specialty pharmacy medication management (clinical pharmacist review, proactive refill management and adherence support, and insurance benefit investigation, financial assistance, compliance and adherence packaging as needed).

Please include a Statement of Medical Necessity

Provider Signature X	Date
Printed Name	

My signature for this prescription also authorizes OptiMed Health Partners and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.

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