

OUTPATIENT INFUSION CENTER  
ORANGE REGIONAL MEDICAL CENTER  
NEW PATIENT INTAKE FORM  
(MUST BE USED EVERYTIME A NEW PATIENT IS BOOKED)

NAME: Bazena Gorczynski

DOB: 4/29/55

PT'S PHONE #: 845 - 726-398

PROCEDURE: Reclast

DATE OF PROC: \_\_\_\_\_

DURATION: yearly

DIAGNOSIS: M81.0

NAME OF PERSON TALKED TOO: Doris

PHYSICIAN & PHONE: 845-342-4774 X4136

INSURANCE: AARP Medicare Complete

ALLERGIES: Penicillin / Anelox

IMMEDIATELY AFTER MAKING THE APPOINTMENT,  
FAX THIS FORM AND COPY OF THE SCRIPT FOR  
AUTHORIZATION AND PRE REGISTRATION PROCESS.

STACY BUDD:  
PHONE: (845) 333-1482  
Fax: (845) 333-1715

CHARLOTTE:  
PHONE: (845) 294-9708 X 296  
Fax: (845) 294-8340

# Reclast®

(zoledronic acid) injection  
5 mg/100 mL for infusion

## Fax Referral Form

Referring Physician's Name:

Dr. K. Ediole

Referring Physician's Phone:

845-342-4774

Referring Physician's Fax:

845-342-1367

Dear Doctor/Infusion Center:

I am referring my patient to you for a Reclast infusion.

J code: J-3488

### Patient Information

Patient Name:

Bazena Gorczynski

SS#:

Patient Address:

12 Bender Rd. Westtown NY 10998 (with patient permission)

Patient Phone:

845-724-3898

Date of Birth:

6/29/1955

### Diagnosis:

☒ Senile osteoporosis (postmenopausal women/men)

ICD-9#

M81.0

☐ Low-trauma hip fracture (use both: code for senile osteoporosis & for fracture site) (see following 3 listings)

• Pathological fracture: Neck of femur

733.01 + 733.14

• Pathological fracture: Other specified part of femur

733.01 + 733.15

• Fracture due to injury: Neck of femur

733.01 + 820.0-820.9

☐ Glucocorticoid-induced osteoporosis

733.09 + E932.0\*

☐ Disorder of bone and cartilage, unspecified (for the prevention of PMO)

733.90

☐ Prevention of glucocorticoid-induced osteoporosis

Primary diagnosis code + V58.65

☐ Paget's disease of bone (osteitis deformans)

731.0

\*Some payers may not require Ecode E932.0 for glucocorticoids causing adverse events in therapeutic use.

This patient has a calculated creatinine clearance of  $\geq 35$  mL/min and a normal serum calcium level: ☐ Yes ☐ No

Date of lab results:

Patient currently taking calcium and vitamin D supplements. ☐ Yes ☐ No

### Insurance Information

Primary Insurance: AARP Medicare Complete

Policy #:

942978972-0

Group #:

Policy Holder:

Secondary Insurance: Champ VA

Phone:

Policy #:

Group #:

Policy Holder:

Attach copies of the following: ☐ Lab results ☐ Prescription ☐ Insurance card(s), front & back

Physician's Signature:

*[Signature]*

Date:

1/10/2020

\*A copy of this information can be given to the patient to bring to his or her appointment.

**FAX BACK INFUSION CONFIRMATION:** (Please update the referring physician by faxing back this form).

Patient name:

Date of infusion:

Infusing Physician Comments:

### Important Safety Information

Reclast is contraindicated in patients with hypocalcemia or hypersensitivity to any component of this product. Reclast contains the same active ingredient found in Zometa® (zoledronic acid) injection and patients receiving Zometa should not receive Reclast. All patients should be instructed on the importance of calcium and vitamin D supplementation. Please refer to Reclast full Prescribing Information for recommendations.

NOVARTIS

Please see accompanying full Prescribing Information.

KOLO-EDIAL  
Endocrinology  
Middletown Medical PC  
111 MALTESE DR. MIDDLETOWN, NY 10940-2113  
Tel: 845-343-4774  
JIC: 020907  
PRACTITIONER DEA NUMBER: BE7320675  
Patient Name: Górczynski Bożena U Date: 01/10/2020  
Address: 17 BENDER RD  
City: WEST TOWN State: NY Zip: 10996  
Age: 64 Y  
Pharmacy Name: Accucare Pharmacy Address: 67 County Highway 108  
Phone: 845-341-2750 Fax: 845-343-1309  
Rx  
Reclast Solution 5 MG/100ML  
Intravenous  
Disp: \*\*\*1\*\*\* (ONE)  
Sig: as directed once yearly 1 dose  
Prescriber Signature: [Signature] MAXIMUM DAILY DOSE  
THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS  
PRESCRIBER WRITES IN BOX BELOW  
REFILLS: \*\*\*0\*\*\*  
Preferred Language: [Box] 0705JH 43  
Dispense As Written: [Box]  
Barcode: [Barcode]

VOID

VOID

VOID

**AARP MedicareComplete**  
Insured through UnitedHealthcare



Health Plan (80840) **911-87726-04**

Member ID **942978972-00** Group Number **66087**

Member  
**BOZENA U GORCZYNSKI**

UHC Dental Benefits

Payer ID:  
**87726**

PCP Name:  
**MCDERMOTT, D.O., JOHN P.**  
PCP Phone: **(845) 986-3311**

**MedicareRx**  
Prescription Drug Coverage **X**

RxBIN: **610097**  
RxPCN: **9999**  
RxGrp: **C03**

Copay: PCP \$10 ER \$80  
Spec \$40

H3307 PEP# 023

AARP MedicareComplete Plan 2 (HMO)  
Oxford Medicare Network

Customer Service Hours: 8 am - 8 pm 7 days/week

Printed: 10/29/2018



**For Members**

Website: [www.myAARPMedicare.com](http://www.myAARPMedicare.com)

Customer Service: 1-800-643-4845 TTY 711

NurseLine: 1-877-368-7949 TTY 711

Behavioral Health: 1-800-985-2596 TTY 711

中文: 1-800-303-6719 한국어: 1-888-201-4746

**For Providers**

[www.UHCprovider.com](http://www.UHCprovider.com) 1-877-842-3210

Medical Claim Address: P.O. Box 31362, Salt Lake City, UT 84131-0362

UHC Dental Providers:

[www.UHCdental.com](http://www.UHCdental.com) 1-877-816-3596

**OXH**

**Renew  
Active**



For Pharmacists: 1-877-889-6510

Pharmacy Claims OptumRx P.O. Box 29045, Hot Springs, AR 71903

**VA**



U.S. Department of Veterans Affairs  
Veterans Health Administration  
Chief Business Office Purchased Care  
CHAMPVA

**Open Access  
No Referral Required**

**Beneficiary Name**

**GORCZYNSKI, BOZENA**

Include this Member Number on all claims and letters

**"Patient SSN"**

**This is your Identification Card**

**Effective Date**

**09/19/2014**

**Expiration Date**

**06/28/2020**

**CHAMPVA**

**1-800-733-8387  
www.va.gov/hac**

VA Form 10-7959-1 May 2014

CHAMPVA pays after most other health plans. Include an explanation of benefits from other insurers. CHAMPVA is primary to Medicaid.

**Once you become eligible for Medicare Part A, you must obtain and maintain Medicare Part B to remain eligible for CHAMPVA**

**For Electronic Claims Filing please follow the instructions at: [www.va.gov/hac/forproviders](http://www.va.gov/hac/forproviders) under "How to File a Claim."**

**For Mental Health/Substance Abuse Authorization**

**Call 1-800-424-4018—Authorization is required:**

- After 23 outpatient mental health visits in a calendar year
- For all other mental health/substance abuse services

**For Durable Medical Equipment (DME) Authorization**

**Call 1-800-733-8387—Authorization is required:**

- For DME purchase or rental over \$2,000

