Magenta Care

Hydration Therapy Referral Form

Please fax this completed referral to Magenta Care: 206-737-3118

Prior Authorization Documentation Required
Please attach all documentation typically required for prior authorization, including:
• Recent History & Physical (H&P;) **or** Provider Progress Notes
• Current Medication List
• Relevant Lab Results (if applicable)

PATIENT DEMOGRAPHICS	
Patient Name:	Date of Birth:
Gender:	❑ Female ❑ Male ❑ Other
Home Phone:	Cell Phone:
Email:	
Address:	
City / State / Zip:	
Legally Responsible Representative:	Relationship:
INSURANCE / FINANCIAL INFORMATION	
Primary Insurance:	Policy / ID #:
Group #:	Subscriber Name:
Secondary Insurance:	Policy / ID #:
❑ Self-Pay (if applicable)	**Relationship to subscriber**
REFERRING PROVIDER INFORMATION	
Provider Name:	Practice / Facility:
Phone:	Fax:
Email:	**NPI:**
CLINICAL INFORMATION	
Primary Diagnosis / ICD-10:	
Secondary Diagnosis / ICD-10:	
Relevant Medical History:	
Allergies:	
Current Medications:	

IV Access (if known): ❑ Peripheral ❑ PICC ❑ Port ❑ Other	
HYDRATION THERAPY ORDERS	
Hydration Solution (e.g., NS, LR, additives):	
Total Volume & Rate:	
Frequency & Duration:	
Start Date:	
Special Instructions:	
PROVIDER AUTHORIZATION	
Prescriber Signature:	Date:
Printed Name & Credentials:	

Fax completed referrals and all supporting documentation to **206-737-3118**. Incomplete submissions may delay referral processing.