UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

Sending a Referral to University of Michigan Health West

Please follow the steps below to send a referral:

1. Review the Required Documentation Checklist below and include listed documents
2. Fill out all fillable fields on the digital form OR print and fill form out manually.
3. Fax completed order form with all required documentation to (616) 475-3118

Required Documentation Checklist

If we do not receive all documents below with your referral or do receive an incomplete medication order form, the order is subject to delays. **It may take up to 14 business days for the patient's insurance company toapprove or deny our authorization request.*

- ☐ Completed Medication Order Form
- ☐ Patient Demographics
- ☐ Current Medication List and H&P
- ☐ Recent Visit Notes
- ☐ Lab Results
- ☐ Patient's Insurance Card
- ☐ Existing Prior Authorization *(if applicable)*

For patients requiring enrollment in co-pay assistance, it is the responsibility of the ordering office to complete and submit enrollment.

The patient will be responsible for submitting an Explanation of Benefits (EOB) and an itemized bill (obtainable through UMH West customer service department) to the co-pay assistance plan.

Solu-Medrol (methylprednisolone)

Order Form

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PATIENT INFORMATION Referral Status: ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

Primary ICD-10 & Description (required): Secondary ICD-10: Tertiary ICD-10:

☐ (required) The patient's demographics, insurance, lab results, meds and recent visit notes attached

Does the patient has an existing prior authorization: ○ Yes (please provide copy) ○ No (UMHWest to obtain)

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

Practice Address:

THERAPY ADMINISTRATION

Solu-Medrol (methylprednisolone) IV:

Dose: ○ 250 mg ○ 500 mg ○ 750 mg ○ 1000 mg ○ _____

Total number of doses: _____

Frequency: ○ Daily ○ Weekly ○ Every 4 weeks ○ Other: _____

*Order expires 12 months from ordering date

Additional Notes from Referring Office:

Provider Name (Print) **Provider Signature** **Date**

UM Health-West Infusion Center

Cascade Campus | 4055 Cascade Rd SE | Grand Rapids, MI 49546

p **616.252.5202** | f **616.475.3118** | UofMHealthWest.org