REQUEST FOR IDPN/IPN SERVICES

Date of Request: _____/ _____/ _____

IN CENTER

☐ IDPN 2 in 1
☐ IDPN 3 in 1 with lipid

In-center Hemodialysis (Complete both): M/W/F T/Th/S Time: _____ am / _____ pm
Requested Infusion Time (Hours): ☐ 2.25 ☐ 2.75 ☐ 3.25 ☐ 3.75

IN HOME

☐ IPN

Peritoneal Dialysis (Check both): ☐ Baxter ☐ Fresenius ☐ CAPD ☐ CCPD
PD RN Name: _____ Email: _____

☐ HHD IDPN 2 in 1
☐ HHD IDPN 3 in 1 with lipid

Home Hemodialysis (Check both): Start time: _____ am / pm Days: M/T/W/Th/F/Sa/Su
Requested Infusion Time (Hours): ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0
Treatments per Week: ☐ 3 Times/wk ☐ 4 Times/wk ☐ 5 Times/wk ☐ 6 Times/wk ☐ 7 Times/wk

Patient's Name: _____

Has the therapy been discussed with the patient? ☐ Yes ☐ No May we contact the patient? ☐ Yes ☐ No

Prescriber's Name: _____ NPI #: _____

Dialysis Unit: _____ Contact's Name: _____

Unit's Address: _____

_____ Contact's Email: _____

Phone: _____ Fax: _____

INSTRUCTIONS

1. Complete entire application and fax form.
2. Please fax this form with requested items to **(800) 355-1029**.

Please obtain & provide the required items below and return with this form.

REQUIRED DOCUMENTATION

☐ Demographic Face Sheet
☐ Current Monthly Composite Lab Work (Three months total)
☐ Allergies: _____
☐ History & Physical Height: _____ cm/in Weight: _____ lb/kg
☐ Supplements Trialed (Dates & Length of Trial): _____
☐ Weight Loss: _____ lb/kg over _____ month(s) **OR** % of weight loss over 3 months: _____% 6 months: _____%
☐ First Date of Dialysis: _____/_____/_____ Social Security Number: _____-_____-_____
☐ Copy of Insurance Card **(front & back)** Medicare Number: _____
☐ Patient Personal Information: ☐ Male ☐ Female

If not on the Demographic Face Sheet, please provide:

Patient's Address: _____
Phone Number: _____

If applicable, please provide: ☐ Nursing Home Information

Name: _____ Phone Number: _____
Address: _____ Admit Date: ____/ ____/ ____

A Pentec Health Intake Coordinator will notify the Unit Coordinator upon coverage determination. You will be contacted if further information is required.

4 Creek Parkway, Boothwyn, PA 19061 Toll free: (800) 223-4376 Fax: (800) 355-1029