

PATIENT INFORMATION FORM



Please fax completed Form to: 800-387-5807

**Phone: 866-XIFAXAN
866-943-2926**

Last Name	First	M.I.	Male/Female	Social Security Number	Date of Birth
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Street Address	City	State	Zip Code	Home Telephone
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Primary Insurance

Company Name

Telephone

Policy ID

Copy of insurance card attached

Please notify patient of research results

I authorize the XIFAXAN Reimbursement HELpline to have access to all medical and insurance coverage information and records which pertain to the patient listed on this form, necessary to verify and/or obtain insurance coverage for XIFAXAN. I further understand that all information and documentation will be held in strict confidence by the XIFAXAN Reimbursement HELpline and will not be shared with any third party except in summary format, after verification of coverage.

Patient Signature

Date

Patient Medical Information

Primary diagnosis:

ICD-9 code (required):

Previous treatment(s):

Regimen (required):

Physician Information

Practice Name:

Tax ID#:

Address:

Fax #:

Physician Signature

Date

Physician Name (Please Print)

Office Contact

Telephone #

<Case ID>

<Template Name>