BIO HEALTH
INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

SELF PAY REQUEST FORM

LOCATION (Required)

LOCATION NAME: _____

PATIENT INFORMATION (Required)

PATIENT NAME:	DOB:	SEX: ☐ MALE ☐ FEMALE
ADDRESS:	PHONE #:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:
Current Insurance:	Do you have a federal insurance, such as Medicare or Medicaid?	
Medication:		
Dosing:	Frequency:	

PHYSICIAN INFORMATION (Optional)

Physician Name:	Office Contact Email:
Practice Name:	Phone Number:
Office Contact:	Fax Number:

Additional Comments:

Fax Referral Form To: (786)219-3917 | Have a Question? (786)460-6044
8684 SUNSET DRIVE MIAMI FL 33143