

ALLERGY VIAL(S) RE-ORDER FORM

NAME _____ DATE REQUESTED _____

ADDRESS _____

CITY _____

STATE _____

ZIP CODE _____

PLEASE CHECK APPROPRIATE BOXES BELOW

FOOD

INHALANT

MAINTENANCE (CONC)

VIAL #1

VIAL #2

VIAL #3

NON MAINTENANCE (ANTIGEN NUMBER)

VIAL #1

VIAL #2

VIAL #3

NO PHONE ORDERS ACCEPTED

MAIL/EMAIL FOR INHALANT VIALS 2 WEEKS BEFORE NEW VIAL NEEDED

MAIL/EMAIL FOR FOOD VIALS WHEN YOU RECEIVE 16TH INJECTION

THE FOLLOWING INFORMATION MUST BE COMPLETED IN ORDER TO RECEIVE YOUR VIAL

Current Insurance Company: _____

Claims Address: _____

Policy #: _____

Group #: _____

Effective Date: _____

Please update this vial card:

*You are responsible for providing our office with your insurance and any authorizations that may be required.