Cycler Request Form

ALL FIELDS ARE REQUIRED. THIS FORM MUST BE SIGNED BY A PHYSICIAN.
EMAIL COMPLETED FORM TO global_corp_hcs_floor_manager@baxter.com

Clinic Name: _____

Patient Name: _____ **Patient #:**_____

Name of individual completing form: _____

Phone # of individual completing form: _____

Description of Need – Please describe the patient's need for Homechoice Claria vs. current cycler:

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Form must be signed by a physician.

By signing below, you are attesting to the truth and completeness of the statements made regarding the patient identified on this form.

Physician Name (Printed): _____

Physician Signature: _____

NPI #:_____ **Date:** _____

FOR BAXTER USE ONLY
Approved _____ **Not approved_____**
CCO#:_____ **Agreement Owner #:**_____

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