New Prescription Fax Form

PrescriptionSolutions®

1 PATIENT — please fill out Section 1, then have your physician fill out Section 2 and FAX to 1.800.491.7997.
NOTE: THIS FAX IS VOID UNLESS RECEIVED DIRECTLY FROM YOUR PHYSICIAN'S OFFICE.

Primary Member ID Number: Plan Name:	(additional coverage, if applicable) Secondary Member ID Number: Plan Name:

Last Name	First Name	MI

Delivery Address	Apt. #

City	State	Zip	Phone Number ( )

Gender ☐ M ☐ F	Date of Birth (mm/dd/yyyy) / /	e-mail

Payment & Shipping Information:

☐ **Charge credit card on file.** ☐ **Charge new credit card: (Visa, MasterCard, Discover, American Express)** ☐ **Overnight shipment method.** Add $12.50 to order amount (subject to change)

New Credit Card Number: Expiration Date (Month/Year)

Signature: Date:

I authorize Prescription Solutions to maintain my credit card on file as payment method for any future charges or outstanding balances. To modify your payment selection, please contact Customer Service.

Medication Allergies: ☐ None

☐ Amoxicillin/Ampicillin	☐ Codeine	☐ Penicillin	☐ Tetracyclines
☐ Aspirin	☐ Erythromycin	☐ Quinolones (e.g. ciprofloxacin)	☐ Other: _____
☐ Cephalosporins (e.g. cephalexin)	☐ NSAID (e.g. ibuprofen)	☐ Sulfa Medications	☐ Other: _____

Over-the-counter/Herbal medications taken regularly:

Notes to Pharmacy:

2

PHYSICIAN — please fill out Section 2, or attach your office prescription.

FAX to

1.800.491.7997

Physician Direct Line: 1.800.791.7658.

Health care information is personal and sensitive information related to a person's health care.

This communication and any attachments are intended solely for the use of the addressees named above and contain confidential and legally privileged information. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you received this communication in error, please notify Prescription Solutions by fax or phone immediately.

Patient Name:	DOB:

Drug

Sig

Quantity
(90 days preferred)

Refills ☐ 1 ☐ 2 ☐ 3 ☐ Other: Dispense as written ☐ Yes

Physician Name	NPI	DEA
Address	Phone Number ( )	
City	State	Zip
Signature	Date	