Prescription Fax Order Form

PATIENT INFORMATION

Patient's Name _____ DOB (MM/DD/YYYY) _____

Street Address _____

City/State/Zip _____ Email _____

Allergies _____ Phone _____

PRESCRIBER INFORMATION

Prescriber _____ Office Contact Name _____

NPI# _____ DEA# _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Medication	Strength	Directions	Qty	Refill
Metronidazole Tablets **NDC:** 58657-0739-56	125 mg	250 mg PO TID × 7 days (i.e., 2 tablets three times daily). Take 2 tablets by mouth three times daily for 7 days ALT Sig	**1 bottle** (56 tablets) QTY:	1 ☐ 2 ☐ 3 ☐ 4 ☐

ICD-10 and Diagnosis _____

Prior Medication Trials/Failures (treatment name, duration, and reason for discontinuation) _____

_____

_____

_____

Commercial Insurance Information

Member Name (cardholder) _____ Rx Plan Name _____

Prescription Drug Card Member ID# _____ Rx Group _____

Rx BIN _____ Rx PCN _____

Prescriber Signature _____ Date _____

Transmitted by (Full Name) _____ Fax _____

Write-In Rx

DISCLAIMER: By signing this form, I hereby authorize a capable and licensed pharmacy (the "pharmacy") to dispense and deliver all prescriptions as prescribed by my physician and to bill my insurance accordingly. I consent to have the pharmacy to contact me accordingly when my prescriptions are ready for refill. I understand that I may opt out of this service at any time. I also understand that the billing of my insurance does not guarantee payment and I may still be subject to financial responsibility including deductibles, copayments and any other payment required by my insurance plan. I further agree to be contacted by text or email at the provided number and email address if necessary and may opt out at any time. I understand that communications sent by text message over an open network or by unencrypted email are inherently unsecure, and there is no assurance of confidentiality of information communicated in this manner. I am aware that additional text message fees may apply. Nevertheless, I wish to communicate by email and text messages if I have provided my contact information and accept full responsibility for emails and/or text messages sent to or from this address or number. I am free to use any other pharmacy provider of my choice. I am not obligated to use this service.

Patient Signature _____ Date _____

**This form is intended for office and clinic use only. This is not to advertise or promote claims of efficacy for any formulations.*

Disclosure Statement: You are free to use any other pharmacy provider you choose. You are not obligated to use this service.