Pharmacy Form

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescription to mail-order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide information for additional pharmacies to be used as an alternative. In addition, if you have a mail-order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

Patient Name: _____ Date of Birth: _____

Main Pharmacy

Name (CVS, Rite Aid, etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

Additional Pharmacies

Name (CVS, Rite Aid, etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

Name (CVS, Rite Aid, etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

Mail Order Pharmacies

- ○ Express Scripts
- ○ CVS Caremark
- ○ OptumRX
- ○ CenterWell
- ○ Other_____