Prescription Fax Form

Community Health Pharmacy

Prescriber Fax Line:
1-877-899-2622

158 Brentwood Drive, Suite #7 • Colchester, Vermont 05446

Patient: This form can only be submitted by your doctor to ensure only faxed prescriptions that are authorized by your prescriber are accepted. Please fill out sections 1,2, and 3 only.

1 PATIENT INFORMATION

❑ Check here if your patient information is already on file with Community Health Pharmacy.

Name: _____ D.O.B.: ☐☐ - ☐☐ - ☐☐☐☐ Sex: ❑ Male ❑ Female

Billing Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____ Daytime Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

❑ Check here if shipping address is the same as billing address. Evening Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Shipping Address*: _____ Physician Name: _____

City: _____ State: _____ Zip: _____ Clinic: ☐ CHCB ☐ CHSLV ☐ THC ☐ NoTCH ☐ NCHC

*Your prescriptions will be mailed to the shipping address on file.

2 DRUG ALLERGIES & CHRONIC ILLNESS

Drug Allergies: ❑ None ❑ Codeine ❑ Sulfa ❑ Aspirin ❑ Penicillin ❑ Other _____

Severity of Drug Allergies: ❑ Mild ❑ Moderate ❑ Severe ❑ Anaphylaxis

Chronic Illnesses: (Disease States) ❑ Thyroid ❑ High Blood Pressure ❑ Heart Condition ❑ Intestinal Disorders ❑ Diabetes ❑ Lung Condition ❑ Glaucoma ❑ Other _____

3 INSURANCE AND BILLING INFORMATION

❑ I have no prescription drug coverage through my medical insurance.

❑ I have Medicare Part D. My Social Security number is: ☐☐☐ - ☐☐ - ☐☐☐☐

❑ I have Medicaid.

❑ I have insurance. My prescription drug carrier is: _____

Relationship to Cardholder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Cardholder ID: _____ Group ID: _____

To process your prescriptions quickly, please provide a credit card number.

❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

_____
Name of Responsible Party

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date: ☐☐ ☐☐☐☐ MM/YYYY

❑ Check here to decline keeping credit card number on file.

X _____
Signature of Cardholder

STOP **PATIENTS, STOP HERE.**