214 E Fulton Grand Rapids MI 49503
Phone: 616.301.8200
FAX THIS FORM TO:616.301.8201

Medication Request Form

Patient Information

Date:________________________ Patient SS#__________________________ ☐ Male ☐ Female
Patients first name___________________________Patient's last name____
Address____
Home Phone_____________________Work Phone_________________________Cell Phone_______________________________
DOB____________________________Weight__________________________kgs or lbs (circle one) Recorded Date_____________
Caregiver____Allergies____

Insurance Information (fill out entirely OR fax copy of patient's insurance card - both sides)

Employer_____________________________________ Secondary Insurance ____
Insured _____________________________________ Insured ____
Phone:______________________________________ Phone____
Policy#______________________________________ Policy#____

Medication

	Medication	DOSE	ROUTE	FREQUENCY	LENGTH	CYCLE	REFILLS
1.	___________	_____	_____	_____	_____	_____	#____X ____MONTHS
2.	___________	_____	_____	_____	_____	_____	#____X ____MONTHS
3.	___________	_____	_____	_____	_____	_____	#____X ____MONTHS
4.	___________	_____	_____	_____	_____	_____	#____X ____MONTHS
5.	___________	_____	_____	_____	_____	_____	#____X ____MONTHS
6.	___________	_____	_____	_____	_____	_____	#____X ____MONTHS

PRIMARY DIAGNOSIS CODE: ________________________________ SECONDARY DX CODE: ___________________________________

ADDITIONAL NOTES:

____

____

HEALTH PLAN or PBM Authorization Number (if required)

____

Today's Date_______________________Date Shipment Needed_____________________ Ship to: ___Patient___Physician/Clinic___Other
Physician's name: (please print)____
Phone Number________________________________Physician's Fax Number____
Office Address____
License#____UPIN#______________________MEDICAID Provider#______________________
Physician's signature____ M.D. DEA#____
Contact person____

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