General

**Prescription Referral Form** Bushnell: Phone: 1.352.793.8000 Fax: 1.352.793.8007

Wildwood:Phone: 1.352.748.9900

Fax: 1.352.748.9902





## www.safescriptpharmacy.com

1. Patient information									
Patient Name:				SSN:			DOB:		
Address:			City	<u> </u>		State:		Zip:	
Home Phone:		Cell Phone:			Email Address:				
<b>Sex:</b> □Male □Female	Height:	Wei	ight: $\square$	lbs. □ kg.	Known Allerg	ies:			
2. Insurance Information:									
Please fax front and back co	py of all Insuran	ce cards (Presc	ription and M	edical)					
3. Diagnosis/Clinical Infori			·	·					
Please fax recent clinical not		ts with the pre	scription to ex	nedite the P	rior Authorization				
Diagnosis:	20, 1420, 4114 100	to with the pre		pourio irro r	ICD-10:				
4. Prescription Information: For IV medications attach a copy of your prescription									
The resemption in ormatio	m. For IV medice	icions accaem a	copy or your p	n escription			·		
Medication	Dose	e/Strength	Max. Daily Dosage	-			(	Qty.	Refills
П									
П									
Ship to:  Patier	nt 🗆 Office 🗆	Other	1						
4. Physician Information:			INIECTIO	ON TRAININ	G: Office to	nstruct	SP to Arr	ange	Teaching
Prescriber Name:		P	rescriber NPI:		o. 🗀 onice to	DE/		апвс	reacrims
Address:			City:		State	-		Zip:	
Tax ID#:				nary Office Co				<u></u>	
Fax Number:	Pho	ne Number:			ffice Contact Email	:			
Prescriber Signature: Prescriber, please sign and date below  *I authorize SafeScript Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.  □ Dispense as Written □ Substitution Permissible									
Prescriber's Signature	ш изрепѕе	as WIILLEII		Ц	Date	ווטטוטוב			
riescriber s signature					Date			_	
Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health insurance Portability and Accountability Act (HiPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information which is exempt from distributing this information with the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.  This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.									
	inis p	rescription is valid of	ily if traffsmitted by	iacsimile macnine	by a licensed prescriber.				