MedScripts MEDICAL PHARMACY
1325 Miller Road Suite K
Greenville, SC 29607
Phone: 1-866-840-4067

Patient Referral

Please fax completed form to: 1-866-514-8299

1 PATIENT INFORMATION

Patients Name:		SSN#:		DOB:
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female
Email Address:			Diagnosis Code:	
Allergies:				

2 INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	ID#:	Group#:
Secondary Insurance Co:	Phone:	ID#:	Group#:

3 PRESCRIPTION INFORMATION (or attach copy of your script)

Medication:	Dose:	Qty:	**Refills:**
Directions:			
Medication:	Dose:	Qty:	**Refills:**
Directions:			
Medication:	Dose:	Qty:	**Refills:**
Directions:			
Medication:	Dose:	Qty:	**Refills:**
Directions:			
Medication:	Dose:	Qty:	**Refills:**
Directions:			

NOTES:

4 PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
NPI#:	DEA#:	Deliver To: ❑ MD Office ❑ Patient Home	

Prescriber Signature
(Physician attests this is his/her legal signature. NO STAMPS)

Date

Injection Training:

- ❑ Office to Instruct
- ❑ Medical Pharmacy to Arrange Teaching

Your signature authorizes MedScripts Medical Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.