PRXP | PHYSICIANS Rx PHARMACIES

FAX OR ESCRIPT ALL PRESCRIPTIONS TO

# PHYSICIANS RX PHARMACY

9701 Apollo Drive, #400 | Largo, MD 20774

**Telephone: (888) 330-2153 Fax: (866) 354-1868**

Clinic Name: 340B Eligible: Yes No

Today's Date: PCP: ________________________

| PATIENT INFORMATION (REQUIRED INFORMATION) | | | | |
|---|---|---|---|---|
| **Patient's Last Name:** **First:** **Middle:** | | | Sex: (Check One) ❑ Male ❑ Female | Birth Date: / / |
| Street Address: | Gender Identity: Male Female Transgender Other: | Home Telephone Number: ( ) | | |
| P.O. Box: | City, State, Zip: | Emergency Contact: | Emergency Contact Phone Number | |

| CURRENT PHARMACY INFORMATION | | |
|---|---|---|
| Pharmacy Name | Telephone Number ( ) | Fax Number ( ) |
| Street Address | City, State | ZIP Code |

| INSURANCE INFORMATION (ATTACH FRONT AND BACK OF INSURANCE CARD) | | | | |
|---|---|---|---|---|
| Policy Insurance | | PCN | BIN | |
| Subscriber's Name | Group Number | Patient ID | | |
| Patient Relationship to Subscriber (Check One) | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |

| DELIVERY INFORMATION (CHECK ONE) | | |
|---|---|---|
| ☐ Patient's Address: | ☐ Prescriber's Address | ☐ Other Street Address City, State, ZIP (Print Clearly) |

## ACKNOWLEDGEMENT FORM
(PLEASE SIGN)

***BY SIGNING BELOW, I AUTHORIZE PHYSICIANS RX PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.***

***BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRATICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM.***

______________________________ ____________

*Patient/Guardian Signature* *Date*

**Licensed in MD, DC, and IL*