



GENERAL PRESCRIPTION REFERRAL FORM

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Today's Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
Ship to Patient at Home Work **OR** Patient will pick up at Physician Office V-Care Pharmacy Date Needed _____
ICD-10 Code _____ Diagnosis _____ Allergies _____
Testing Yes No Results _____ Patient currently on therapy Yes No Date of next blood work _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PRESCRIPTION # 1

Medication _____ Dosage _____ Quantity _____ Directions for use _____ Refills _____ Signature _____

PRESCRIPTION # 2

Medication _____ Dosage _____ Quantity _____ Directions for use _____ Refills _____ Signature _____

PRESCRIPTION # 3

Medication _____ Dosage _____ Quantity _____ Directions for use _____ Refills _____ Signature _____

PRESCRIPTION # 4

Medication _____ Dosage _____ Quantity _____ Directions for use _____ Refills _____ Signature _____

PRESCRIPTION # 5

Medication _____ Dosage _____ Quantity _____ Directions for use _____ Refills _____ Signature _____

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required, NO STAMPS) _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.