WAYS TO OBTAIN YOUR MEDICATION REFILLS

Refills are available **ONLY BY MAIL**. Ensure your address on file is current before requesting refills.

Request refills at least **2 to 3 weeks** before you are out of medication(s).

1. USE OUR AUTOMATED TELEPHONE SYSTEM

Pharmacy Automated Telephone Instructions:

1. Dial **1-800-209-7377**
2. Press **1** for prescription refills.
3. For English press **1**. For Spanish press **2**.
4. Enter your SOCIAL SECURITY NUMBER (9 digits)
5. Then press the # (pound key)
6. Press the number **2** for pharmacy prescriptions.
7. Press the number **1** for prescription refills.
8. Enter the **Rx #** (prescription number): _____ and then press **#**. Then press **1**. (Enter only the Rx #. Do **NOT** enter letters. The computer will not accept letters.)
9. Repeat step 8 until you have entered all of the prescriptions that you need refilled.

Prescriptions should arrive within **7 to 10 working days. Prescriptions are filled at various locations including Dallas CMOP. Call us at 1-800-983-0933 for further assistance.**

-OR-

2. USE THE INTERNET

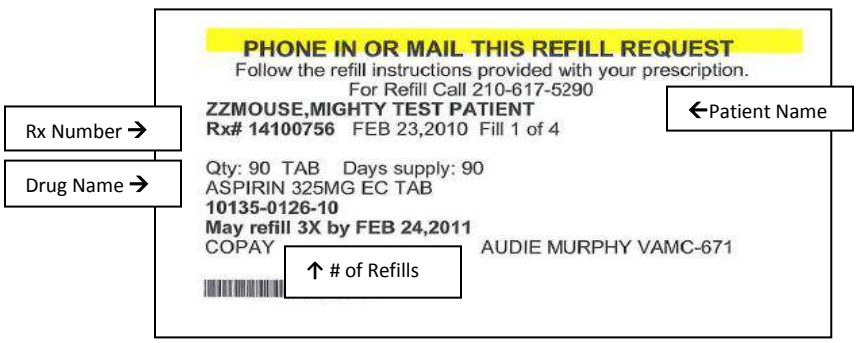
Order prescriptions online at www.myhealth.va.gov.

-OR-

3. USE THE MAIL BY SENDING REFILL SLIPS

Mail refill slip(s) for the prescription that you need to the address below. (Tip: Consider mailing back the slips as soon as you receive your prescriptions via mail.)

Mail refill slips to:
Kerrville VAMC
PHARMACY SERVICE (119)
3600 Memorial BLVD.
Kerrville, TX 78028



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-OR-

4. USE THE MAIL BY SENDING A PHARMACY REFILL REQUEST FORM

1. Write your **Full Name**, **Date of Birth**, **Name Of Medication(s)** and the **Rx #** (prescription number) of medication(s) needed on a piece of paper or fill out the form below. (Tip: Use the Kerrville VAMC return address sticker provided with your prescription to mail back refill requests.) **Request refills at least **2 to 3 weeks** in advance.**
2. Mail request form to:

Kerrville VAMC
PHARMACY SERVICE (119)
3600 Memorial Blvd.
Kerrville, TX 78028

PHARMACY REFILL REQUEST FORM

Patient's Full Name: _____

Date of Birth: _____/_____/_____

WRITE THE NAME OF THE MEDICATION(S) AND Rx NUMBER(S)

1. _____Rx #_____
2. _____Rx #_____
3. _____Rx #_____
4. _____Rx #_____
5. _____Rx #_____
6. _____Rx #_____
7. _____Rx #_____
8. _____Rx #_____
9. _____Rx #_____
10. _____Rx #_____

Prescriptions will be mailed to your **current address on file.**

PHARMACY HOURS
MONDAY through Friday 8:00 AM to 5:30 PM
Closed SATURDAY, SUNDAY and HOLIDAYS