Specialty Medical & Surgical Supplies

GENERAL PRESCRIPTION REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | Fx 508.202.9343

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**

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.