Pharmacy Information

New York State law requires prescriptions to be electronically submitted to your pharmacy. Please indicate where you would like your prescriptions sent.

Patient Name _____ DOB _____

Name of local pharmacy: _____

Pharmacy address: _____

_____

Pharmacy phone number: _____

Some insurers require "maintenance medications" (those medication which you will continue to take for months or more) to be processed through a "mail-away" pharmacy instead. Please indicate how we should process your maintenance medications:

Your mail-away ID # _____

Mail-away pharmacy name: _____

Mail-away pharmacy address: _____

_____

Mail-away pharmacy phone # _____

Mail-away pharmacy fax # _____

Please provide us with a copy of your pharmacy ID card*

_____ _____

Patient Signature Date Signed