

FAX OR ESCRIPT ALL PRESCRIPTIONS TO
PHYSICIANS RX PHARMACY
9701 Apollo Drive, #400 | Largo, MD 20774



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

340B Regular PREP T&T

Clinic Name: _____

340B Eligible: Yes No

Today's Date: _____

PCP: _____

PATIENT INFORMATION (REQUIRED INFORMATION)

Patient's Last Name: _____ First: _____ Middle: _____ Preferred: _____ Birth Date: __/__/____

Sex (Check One): Male Gender Identity: Male Female Pronouns: _____
 Female Transgender Other: _____

Street Address: _____ P.O. Box: _____ City, State, Zip: _____

Home Phone: _____ Emergency Contact: _____ Emergency Contact Phone: _____

Any known allergies: _____ ***Please attach copy of drivers license or photo ID**
 Check to Indicate Copy Attached

CURRENT PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

PRESCRIPTION INSURANCE INFORMATION (ATTACH FRONT & BACK OF INSURANCE CARD)

Check to Indicate Front/Back of Insurance Card is Attached

Policy Insurance: _____ PCN: _____ BIN: _____

Subscriber's Name: _____ Rx Group Number: _____ Patient ID: _____

Patient Relationship to Subscriber (Check One): Self Spouse Child Other: _____

DELIVERY INFORMATION (CHECK ONE)

Patient's Address (Street Address: _____ City, State, Zip: _____)

Prescriber's Address (Street Address: _____ City, State, Zip: _____)

Other (Street Address: _____ City, State, Zip: _____)

ACKNOWLEDGMENT 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 PRACTICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM.

Patient/Guardian Signature

Date

*Licensed in MD, DC, FL, IL, NY, and VA