☐ FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
☐ DALLAS / 3410 Worth St., Ste. 790, Dallas TX 75246

TEL: **817-336-1640** FAX: **817-336-1643**

PATIENT INFORMATION:				**PRESCRIBER INFORMATION:**		
Patient Name:				Prescriber Name:		
Address 1:				DEA:		
Address 2:				NPI:	License:	
City:	State:	Zip:		Address:		
Home Phone:	Alt:			City:	State:	Zip:
DOB:	SSN:	Gender: ☐ Male ☐ Female		Phone:	Fax:	
Language: ☐ English ☐ Spanish ☐ Other				POC:	Email	

INSURANCE INFORMATION: (Complete entirely or fax front and back of patient's prescription card)					
Prescription Card:	Name of Insurer:	ID#	BIN:	PCN:	GROUP:
Primary Insurance:	Subscriber:	ID#	Name of Insurer:	Phone:	
Secondary Insurance:	Subscriber:	ID#	Name of Insurer:	Phone:	

PRIOR AUTHORIZATION: ____

CLINICAL INFORMATION:	**PATIENT HISTORY:**	
Diagnosis ☐ **ICD-10 Code:** ☐ ☐ Other: ______________________________	Weight ☐ kg ☐ lb	Height ☐ cm ☐ in
	☐ NKDA ☐ Allergies	
	Comorbidities:	
	Concurrent Meds:	

PRESCRIPTION INFORMATION:

Medication	Dose	SIG		Refills

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber Signature: ______________________________ Date: ______________________