US Specialty Care

Patient Prescription Form
Specialty Program
-CONFIDENTIAL-

Please complete and fax to the following dispensing pharmacy
US Specialty Care
1-800-641-8475 phone
1-800-530-8589 fax

Physician Information

Physician's Name:
Address:
City:
State: Zip:
Office Contact:
Telephone:
Fax:
UPIN #:
State License #:
DEA #:

Patient Information

Patient's Name:
Address:
City:
State: Zip:
Date of Birth: / / Sex: ❑ M ❑ F
Social Security #:
Daytime Telephone #:
Evening Telephone #:
Height: Weight:
Allergies

Primary Insurance Information

Insured's Name:
Relationship:
ID #:
Policy #:
Carrier/Group #:

Other Insurance Information

Insurance Company:
Policy #:
Group #:
Insured's Name:
Relationship:
Social Security #:
Date of Birth: / /

Clinical Information

Diagnosis Code: _____ Primary Diagnosis: _____

Prescription Medications	Strength	Directions (Dose/Route/Frequency)	Quantity/Length
1)_____	_____	_____	_____
2)_____	_____	_____	_____
3)_____	_____	_____	_____
4)_____	_____	_____	_____

# of Refills: _____ Physician's Signature: _____ Date: _____ DAW: __

Form of Payment

Form of Payment: ❑ Visa ❑ Master Card ❑ Discover ❑ American Express
Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiration Date _____
Cardholder's Name: _____ Signature* _____
*Credit Card will be used for all future orders.

Delivery Instructions

Ship to: ❑ Physician's Office
❑ Patient's Home
❑ Other
Delivery Date: Refill Date:

If Other, please supply:
Address:
City:
State: Zip:

Rev 04/05