iPack PHARMACY

TRANSFER MY PRESCRIPTIONS

Name: _____ DOB: _____

Address: _____ Phone: _____

What type of insurance do you have? Please check the box that applies to you:

☐ State Insurance ☐ Commercial Insurance

CURRENT PHARMACY INFORMATION (If you have more than one pharmacy, please list)

Pharmacy: _____ Phone: _____

Address: _____

Pharmacy: _____ Phone: _____

Address: _____

Do you have any drug allergies? Please list:

_____ _____ _____

_____ _____ _____

List of medications you would like to transfer (Please attach medication list if possible):

1. _____ 6. _____ 11. _____
2. _____ 7. _____ 12. _____
3. _____ 8. _____ 13. _____
4. _____ 9. _____ 14. _____
5. _____ 10. _____ 15. _____

What other free services would you like to use (Check all that applies)?

☐ Medication Therapy Management ☐ Free Prescription Delivery

☐ Simplify My Meds ☐ Medication Packaging

Name of Preparer: _____ Phone: _____

Signature: _____ Date: _____

Signature of Patient _____ Date _____

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