

Please note: Banks Apothecary can accept only original prescription drug orders from patients.
 Faxed prescriptions can be accepted only from the prescribing practitioners.

PATIENT INFO		PRESCRIBER INFO	
Last Name, First Name	SSN	Today's Date	DEA #
Date of Birth		Prescriber Name	NPI #:
Home Phone Number	Other Phone Number	Address	City, State Zip
Home Address	City, State Zip	Phone Number	Fax Number
Shipping Address (if different from home address) Licensed to practice and ship to: DE/PA/MD/NJ/NY/VA		Office Contact Prefers: __Fax__ Phone	

INSURANCE		
Rx ID		
RXGRP#	RXBIN#	RXPCN#
Rx ID (if secondary insurance)		
RXGRP#	RXBIN#	RXPCN#

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

CLINICAL INFORMATION

Please provide any drug allergies (if applicable):

ATTACH PRESCRIPTION HERE

Rx	DRUG:	
	SIG:	
REFILLS: _____	QTY TO DISPENSE: _____	SHIP TO: HOME__ OFFICE__
Prescriber Signature: _____		DATE: ____/____/____