SSEHPMEDS DOCTOR'S OFFICE FAXED MEDICATION ORDER

Toll free phone: 1-866-893-MEDS (6337) Toll free fax: 1-866-715-MEDS (6337)

PATIENT

First Name Initial Last Name Phone (*Home*)

Indicate **any change** in your health or existing medications below: Birthdate _____
DD/MM/YYYY

PROVIDER

U.S. Physician Name Phone Fax

Street Address City, State, Zip Code

Please answer the following as it applies to this Patient:

1. Has this Patient been taking this medication (s) for at least 30 days? ☐ **YES** ☐ **NO**

2. If the answer to Question #1 was **"NO"** (ie. This is a new prescription (s)), has the Patient shown that they can tolerate this medication? ☐ **YES** ☐ **NO**

ALL PRESCRIPTIONS SHOULD ACCOMPANY THIS FORM

If **FAXING:** Make sure your Physician attaches all medication orders to one form.

Your ORIGINAL prescription (s) is (are) to remain on file with your prescribing Physician.

Number of prescription (s) attached. _____

FAX TOLL FREE DIRECTLY FROM YOUR DOCTOR'S OFFICE 1-866-715-6337

If **MAILING:** Please forward your ORIGINAL prescription (s) with this form to:

SSEHPMeds
P.O. Box 44650
DETROIT,MI
48244-0650

If you or your Physician have any questions, please contact our Customer Representatives toll free at 1-866-893-6337.

Patient Signature (Parent / Guardian if Patient is Under Age 18) **Date**