OPWDD – Metro DDSO

PharMerica®

PHARMACY FAX# 1-844-331-4156

Complete form and FAX to PHARMACY

for ADMISSIONS / DISCHARGES

SITE NAME:	
FAXED BY:	
DATE:	

SITE NAME:	
ADMISSION DATE:	
CLIENT NAME:	DATE OF BIRTH:
SOCIAL SECURITY #:	
BILLING STATUS: MEDICARE (NUMBER)	MEDICAID (NUMBER)

FOR PRIVATE INSURANCE (or FAX/ATTACH copy of card)

INSURANCE NAME:	NUMBER:
ADDRESS:	PHONE NUMBER(S):
ALLERGIES:	

DISCHARGE DATE:	CLIENT NAME:

____ DISCHARGED TO: **Home** ☐ **Hospital** ☐ **Other** ☐

____ EXPIRED