

**PHARMACY FAX# 1-844-331-4156**  
**Complete form and FAX to PHARMACY**  
**for ADMISSIONS / DISCHARGES**

<b>SITE NAME:</b>
<b>FAXED BY:</b>
<b>DATE:</b>

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:
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\_\_\_ DISCHARGED TO: 

Home <input type="checkbox"/>	Hospital <input type="checkbox"/>	Other <input type="checkbox"/>
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\_\_\_ EXPIRED