



Physician Referral

Fax to 866-406-4215

Customer Service: 866-406-4209

MEDICA®

Patient Information Please type or print clearly.	Name		
	Address		Date of Birth
	City	State	ZIP Code
	Spouse Name/Parent(s)/Other		
	Home Phone w/area code		Work Phone w/area code
Insurance Information <input type="checkbox"/> Major Medical <input type="checkbox"/> Rx Benefit Please attach a copy of card(s) if possible.	Primary Insurer		
	Cardholder		
	Date of Birth		
	Cardholder ID #		Group #
	RxCARD ID #	RxBIN #	RxGroup #
	Phone w/area code		Fax w/area code
Health Conditions	<input type="checkbox"/> Diabetes (250) <input type="checkbox"/> Glaucoma (365) <input type="checkbox"/> Arthritis (715) <input type="checkbox"/> Hypertension (401) <input type="checkbox"/> Stomach Disorders (536) <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Heart Disease (402) <input type="checkbox"/> Thyroid Disorders (246)		
	Allergies <input type="checkbox"/> Codeine (32) <input type="checkbox"/> Sulfa (87) <input type="checkbox"/> Other (please list) _____ <input type="checkbox"/> Penicillin (70) <input type="checkbox"/> Tetracycline (93) <input type="checkbox"/> No known allergies		
	Prescription IMPORTANT: Prescription must be faxed from a physician's office. Facsimile not valid for C-II prescriptions.		
Quantity _____ Refill x _____		Quantity _____ Refill x _____	
Physician Certification <input type="checkbox"/> Please acknowledge receipt of this fax.	I certify that the above therapy is medically necessary and the information above is accurate to the best of my knowledge.		
	MD Signature (required)		Date
	Print MD Name		
	Form Faxed by		UPIN
	Address		DEA #
	City	State	ZIP Code
	Contact		
	Phone w/area code		Fax w/area code

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