Name:	Today's Date:
DOB:	Delivery Type (circle one) Mail Delivery
Insurance Name: _____ Name on Card: _____ (Medicaid #) : _____ RxPCN: _____ RxBin: _____ Rx Cust Srvc #: _____	If delivery, specify authorized individual(s) to sign for medication. Name: Phone #: _____ _____ _____ _____ _____ _____
Allergies:	
Additional Information:	

Your doctor has prescribed medications for delivery. The specific prescription(s) ordered by your doctor will be delivered to you or mailed to your current address.

Expect A Call

A PPM Pharmacy representative will contact you for all pertinent information as soon as we receive your prescription. A pharmacist will then go over what was prescribed, how to use it appropriately, what you can expect when using the prescription and answer any questions you might have.

Cost and Shipping

There is no cost to you for delivery or shipping. Your normal prescription copayment will be due at time of service.

IF WE HAVE NOT SUCCESSFULLY CONTACTED YOU WITHIN 24 HOURS,

Please call PPM at (405)604-6861 or Toll Free at 1-855-203-0681
Fax: 405-213-1554