

JORDAN RESES PRESCRIPTION FAX FORM

Please FAX this Completed Form to Jordan Reses Pharmacy:

FAX# 215-729-1040
or **800-838-3971**



To: JORDAN RESES PHARMACY
5739 Chester Avenue
Philadelphia, PA 19143
PHONE: 800-848-4050

From: Name: _____

Date: ____ / ____ / ____

Physician/Health Care Professional Information

MO DAY YR

Address: _____

Phone: (____) _____ **Fax:** (____) _____

PATIENT INFORMATION

Name: _____ **DOB:** ____ / ____ / ____ **SS#:** ____ - ____ - ____

MO DAY YR

Address: _____ **City:** _____

Shipping Address: _____

City: _____ **State:** ____ **Zip:** _____

Description of Patient's Injury: _____

DOI: ____ / ____ / ____ **Day Phone:** (____) _____ **Evening Phone:** (____) _____

MO DAY YR

INSURANCE INFORMATION

Patient's Employer: _____

Insurance Company: _____

Adjuster: _____ **Phone:** (____) _____

Billing Address: _____

Claim Number: _____

MEDICATION	STRENGTH	DOSE/FREQUENCY	QUANTITY	REFILLS

***NOTE: IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HAND WRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE PROVIDED:** _____

Physician's Name (Please print) _____ **State License #:** _____

Physician's Signature: _____ **DEA#:** _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt for disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the addressee, except by express authority of the sender to the named addressees.