

<b>ID #.</b>	<b>GRP #.</b>
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FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-715-(MEDS) 6337  
OR  
MAIL TO: PNWMedS, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

**PATIENT INFORMATION:**

Birthdate \_\_\_\_\_  
DD/MM/YYYY

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

First Name (please print) \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

**NOTE:**  
Please request a **3-month** supply of medication with **3 refills**.

**New-to-you** medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. <i>Ex. Lipitor (This is NOT a prescription.)</i>	Strength <i>Ex. 10 mg</i>	Reason for Taking <i>Ex. Cholesterol</i>	Daily Use <i>Ex. Twice Daily</i>

**MEDICAL HISTORY** (If you require more space, please attach a separate piece of paper.)  Male  Female

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. \_\_\_\_\_

(ii) Hospitalization: (stays in hospital during the past 5 years) \_\_\_\_\_

(iii) Present illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. \_\_\_\_\_

(iv) Drug allergies:  NO  YES If yes, please specify: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Signature: (optional) \_\_\_\_\_ Date: (DD/MM/YY) \_\_\_\_\_

**AUTHORIZATION**  
I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse and that the information provided by me is accurate and true.  
I request and authorize Putnam/Northern Westchester Health Benefits Consortium, NY, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Subscriber Signature: \_\_\_\_\_ Date: (DD/MM/YY) \_\_\_\_\_