

IV. PRESCRIPTION INFORMATION

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription.

Also, include a copy of your pharmacy receipt with this form.

Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: ___/___/___	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:

Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: ___/___/___	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:

Important! A signature is required.

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to Envolve Pharmacy Solutions and my plan sponsor.

Signature: _____

Date signed: _____