PRESCRIPTION REFILL REQUEST

Please complete one (1) form per prescription request

Please allow up to 2 business days for routine prescription refill requests.

Patient's Name:_____ DOB (M/D/Y): _____/_____/_____ **Gender:** ❑M ❑F

Medication Name:_____ Dosage: _____

Directions: _____

Quantity: _____ Refills: _____ Generic permitted: ❑YES ❑NO

****

If requesting prescription refills to the SAME pharmacy, you need to complete this section below only on your first form.

Preferred Phone #: _____ Alternate Phone #: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

If using a mail-order pharmacy, check/write name:

❑ Medco ❑ Express Scripts ❑WellPoint ❑ Caremark ❑ Other _____

Insurance Member ID#: _____

Physician:

- ❑ **Lonnie Herzog, M.D.**
- ❑ **David A. Smith, M.D.**
- ❑ **Samuel F. Adams, M.D.**
- ❑ **Robert A. Diekroeger, M.D.**
- ❑ **Russell C. Maxa, M.D.**
- ❑ **Sandra K. Banks, M.D.**
- ❑ **Scott J. Small, M.D.**
- ❑ **Thomas L. Weeks, III, M.D.**
- ❑ **Amy L. Varner, M.D.**

FOR OFFICE USE ONLY

Primary Care Physicians of Atlanta, P.C.
5670 Peachtree Dunwoody Road, Suite 1200
Atlanta, GA 30342

Phone: (404) 255-9100 **Fax: (404) 257-7171**

❑ Approved above request ❑ Request approved with changes below ❑ Request denied

Medication Name: _____ Dosage: _____

Directions: _____

Quantity: _____ Refills: _____ Generic permitted: ❑YES ❑NO

Comments: _____

_____

Prescribing Physician: **DEA#: _____**

- ❑ **Lonnie Herzog, M.D.** _____
- ❑ **David A. Smith, M.D.** _____
- ❑ **Samuel F. Adams, M.D.** _____
- ❑ **Robert A. Diekroeger, M.D.** _____
- ❑ **Sandra K. Banks, M.D.** _____
- ❑ **Russell C. Maxa, M.D.** _____
- ❑ **Scott J. Small, M.D.** _____
- ❑ **Thomas L. Weeks, III, M.D.** _____
- ❑ **Amy L. Varner, M.D.** _____

Reviewed with physician by: _____ Date: _____

❑ Faxed / ❑ Called to pharmacy #: _____ Date: _____

Patient Contacted by: _____ Date: _____