PHARMACY FAX COVER SHEET

Date: _____ **Time:** _____

Fax Sent To: _____ **Fax Number:** _____

Organization/Hospital/Clinic: _____

Attention: _____

Sender Information

Field	Details
Pharmacy Name	_____
Pharmacist Name	_____
Phone Number	_____
Fax Number	_____
Email	_____

Patient Information

Field	Details
Patient Name	_____
Date of Birth	_____
Patient ID / MRN	_____
Insurance (Optional)	_____

Prescription Details

Field	Details
Prescription (Rx) Number	_____
Medication Name	_____
Strength	_____
Dosage Instructions	_____
Quantity	_____
Number of Refills	_____
Prescribing Provider	_____

Reason for Fax (✓)

☐ New Prescription
☐ Refill Request
☐ Prior Authorization
☐ Prescription Clarification
☐ Medication Change
☐ Insurance Information
☐ Patient Records
☐ Other: _____

Attached Documents

☐ Prescription Copy
☐ Medication List
☐ Insurance Card
☐ Patient Information
☐ Physician Order
☐ Other: _____

Total Pages (Including Cover Sheet): _____

Notes / Comments

Confidentiality Notice

This fax contains confidential health information intended only for the named recipient. If you have received this fax in error, please notify the sender immediately, destroy all copies, and do not disclose or distribute its contents.

Authorized Signature: _____

Date: _____