

# PHARMACY REFERRAL COVER LETTER

DATE:

PRIORITY:

Routine  Urgent

---

FROM (REFERRING FACILITY):

PHONE/FAX:

TO (RECEIVING PHARMACY):

PHARMACIST/CONTACT:

PATIENT INFORMATION:

FULL NAME:

DATE OF BIRTH:

PHONE NUMBER:

INSURANCE/MEMBER ID:

CLINICAL REASON FOR REFERRAL / MEDICATION REQUESTED:

ADDITIONAL DOCUMENTATION ATTACHED:

Prescription(s)

Prior Authorization Forms

Lab Results

Clinical Notes / Medication History

PRESCRIBER SIGNATURE

NPI NUMBER

---

CONFIDENTIAL HEALTHCARE INFORMATION: PROTECTED BY HIPAA