03.2016

FOR: ______________________ DATE: ____________

ADDRESS: ______________________ TEL: ____________

Facsimile not valid for CII prescriptions
Valid only at Samaritan Pharmacy Services

Dr: ______________________ Dr: ______________________
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): ______________________

REFILL ________ TIMES ADDRESS ______________________

DEA # ____________ TELEPHONE # ______________________

FOR: ______________________ DATE: ____________

ADDRESS: ______________________ TEL: ____________

Facsimile not valid for CII prescriptions
Valid only at Samaritan Pharmacy Services

Dr: ______________________ Dr: ______________________
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): ______________________

REFILL ________ TIMES ADDRESS ______________________

DEA # ____________ TELEPHONE # ______________________

SAMARITAN HEALTH PLANS, 2300 NW WALNUT BLVD., CORVALLIS, OR 97330

SAHP-1300

FAX ORDER FORM

____
(print your company name)

PHYSICIAN: Please fax fully completed form to Samaritan Pharmacy Services at **(541) 768-5226**.
TO THE PATIENT: Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Samaritan Pharmacy Services, 3521 NW Samaritan Dr., Ste. 202, Corvallis OR 97330
Refill line: (541) 768-5230. Customer Care Center: (541) 768-5225, toll free 1-866-374-7245.

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription:

- Fully complete the sections below using *black ink only*. A credit card number is required at the time the form is submitted.
- Have your doctor supply the prescription information requested using prescriber's form.
- Have your doctor fax the form to the number above. IMPORTANT: To be valid, the prescription must be faxed from your doctor's office.
- Please allow 1 week for delivery from the date your physician faxes your prescription in.

PLEASE NOTE: By submitting this form, you have authorized release of all information to Samaritan Pharmacy Services (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

SAMARITAN ADVANTAGE MEMBER INFORMATION

ID Number (located on ID card)		
Name (First, Last)		Date of Birth (Mo/Day/Yr) / /
Address		
City	State	Zip Code
Daytime Phone ( )	Evening Phone ( )	

PATIENT INFORMATION

Patient Name (First, Last, if different from above)	☐ Male ☐ Female	Patient Date of Birth (Mo/Day/Yr) / /

PATIENT ALLERGIES:
☐ No Known ☐ 32-Codeine
☐ 70-Penicillin ☐ 87-Sulfa
☐ 93-Tetracycline ☐ Other (list):

PATIENT HEALTH CONDITIONS:
☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension
☐ 400-Heart Disease ☐ 500-Glaucoma ☐ 600-Stomach Disorders
☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

Dr.'s Name	Dr.'s Phone ( )

PAYMENT INFORMATION

PLEASE NOTE: It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Samaritan Pharmacy Services will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center number to advise.

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CREDIT CARD EXP. DATE ☐☐ / ☐☐