Prescription Transfer Form

Patient's Name

Date of Birth | Last 4 digits of SSN

Complete Address (NO PO boxes)

Preferred Phone | Secondary Phone

Email Address

Allergies

Dependent (If Applicable)

Name | Date of Birth

Allergies | Phone

Is there a secondary pharmacy insurance plan?

☐ No ☐ Yes (If yes, staff will contact you for information.)

Preferred Delivery Method (check either Pickup or Delivery and then select your preferred pharmacy)	
☐ Pickup	☐ Home Delivery (delivered from Hoxworth)
☐ UCMC Hoxworth Pharmacy	☐ West Chester Outpatient Pharmacy
☐ UCMC Discharge Pharmacy	☐ Drake Pharmacy
☐ UCMC Physician's Office Building	☐ Business Center pickup at Specialty Pharmacy

Prescriptions for delivery will be processed as received by providers. I authorize the pharmacy staff to bill my credit card/FSA/HSA/debit card on file for my copayments/coinsurance. I understand that any changes to delivery preferences including address changes need to be communicated before shipment occurs.

Signature_____ **Date**_____

CURRENT PHARMACY

Phone		City/State	
Prescription #		Drug Name/Dosage	
Prescription #		Drug Name/Dosage	
Prescription #		Drug Name/Dosage	
Prescription #		Drug Name/Dosage	
Prescription #		Drug Name/Dosage	

Add additional pages if necessary.

Email /Fax completed forms to specified location below:

UCMC Outpatient Pharmacy: Fax 513-584-5270 or UCMCOutpatientPharmacy@uchealth.com

West Chester Outpatient Pharmacy: Fax 513-759-1999 or WCHOutpatientPharmacy@uchealth.com

Specialty Pharmacy: Fax 513-585-9711 or SpecialtyPharmacy@uchealth.com

Non-Specialty Home Delivery/Drake Pickup: Fax 513-584-5270 OR UCMCOutpatientPharmacy@uchealth.com