**PRESCRIPTION FORM**

 **NO…………….……….**

**Patients Name……………………………………………………………..Age……………….**

**Employees Name…………………………………..Relationship to patient……………..**

**Policy Number…………………………………………..Date……………………………………**

**Principal Member…………………………………………………………………………………….**

**Provisional diagnosis……………………………………………………………………………..**

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| **RX** |

**Authorize change of brand if necessary YES NO**

**Physicians Name………………………………………………………………………………..**

**Signature………………………………………………………………..Date………………………**