

Rx FOR: _____ DATE: _____
ADDRESS: _____ TEL: _____

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

Dr: _____ DISPENSE AS WRITTEN Dr: _____ SUBSTITUTION PERMISSIBLE
MAY SUBSTITUTE
PHYSICIAN NAME (PLEASE PRINT): _____
REFILL _____ TIMES ADDRESS _____
DEA # _____ TELEPHONE # _____

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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, 3615 NW Samaritan Dr., Ste. 102, 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)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Date of Birth (Mo/Day/Yr)
		/ /	
PATIENT ALLERGIES:		PATIENT HEALTH CONDITIONS:	
<input type="checkbox"/> No Known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> No Known	<input type="checkbox"/> 200-Diabetes
<input type="checkbox"/> 70-Penicillin	<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> 400-Heart Disease	<input type="checkbox"/> 500-Glaucoma
<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):	<input type="checkbox"/> 700-Thyroid Disease	<input type="checkbox"/> 800-Arthritis
		<input type="checkbox"/> 300-Hypertension	<input type="checkbox"/> 600-Stomach Disorders
		<input type="checkbox"/> 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														
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