

PRESCRIPTION TRANSFER REQUEST



For your convenience, you can have all your prescriptions transferred to Samaritan Pharmacy Services for mail order delivery. Just complete this form and fax or mail to Samaritan Pharmacy Services. We will contact the pharmacies you have listed below and have the prescriptions transferred. Please allow 72 hours for the transfers to take place.

MAILING ADDRESS: Samaritan Pharmacy Services, 3615 NW Samaritan Drive, Suite 102, Corvallis, OR 97330

FAX #: Samaritan Pharmacy Services, (541) 768-5226

Customer Care Center: (541) 768-5225, toll free 1-866-374-7245.

MEMBER INFORMATION			
ID Number (located on ID card)			
Group Number			Date of Birth (Mo/Day/Yr) / /
Name (First, Last)			
Address			Daytime Phone ()
City	State	Zip Code	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) / /
PRESCRIPTIONS TO BE TRANSFERRED			
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:
Rx #:	Pharmacy Name:	Location:	Phone:
Medication:		Prescribing Dr.:	Dr.'s Phone:

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.