DrugSource, Inc. Mail in Refill Form

P.O. Box 1366 - Elk Grove Village, IL 60009-1366 - Fax: (847) 258-1913

Email Address:		Date:	
Paatient Name:		Patient Phone:	

☐ If a generic becomes available call my Doctor to have it changed

Rx#	Drug Name	Strength	Quantity
Total Refills		Total Copay	

☐ I would like to talk to a pharmacist about my medications

Special Instructions
Describe any medication changes here

Employee's Credit Card Information

Card Type		Card Number		Exp. Date	

I certify the information on this form is correct. I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator,underwriter,and sponsor in accordance with the Health Insurance Portability and Accessibility Act(H.I.P.A.A.).

Signature:		Date:	

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