CareLink
University Health System

Prescription Mail Out Request Form

****If paying by Check or Credit Card, please include Texas DL# or Texas ID# in space provided****

Processed by DOWNTOWN PHARMACY ONLY: (210) 358-9654 or (210) 358-9657 or Toll Free (800) 760-9654
If only REFILLS are being requested, complete this form and FAX to (210) 358-9650.

NEW PRESCRIPTIONS must be attached to this form (may not be FAXed) and:	• **mailed to the Downtown Pharmacy (UHC-DT Pharmacy, 527 N. Leona, 78207)** • **or placed in designated drop-off stations**

Name: _____ D.O.B. _____ Daytime Phone #: _____

CareLink #: _____ Home Phone #: _____

****Texas DL# or Texas ID#:** _____ **EXP:**_____ (When paying by Check or Credit Card)

ALLERGIES: ☐ None known ☐ Yes (please list):

Please carefully print mail out information below:

Name: Address: City, State & Zip code:	**(PHARMACY USE ONLY)**

GENERAL INFORMATION and REQUIREMENTS:

- **Please allow at least 14 business days for processing and mailing.**
- **This form MUST be completed each time prescriptions or refills are requested for mail out.**
- **Prescriptions must be written by a UPG/CMA/UHS prescriber.**
- **Controlled Substances cannot be mailed.**

FOR NEW PRESCRIPTIONS:

- **Number of new prescriptions being dropped off or mailed: _____**
- **Please note it is illegal for pharmacies to accept faxes of new prescriptions from patients.**
- **Please do NOT ask your prescriber to call in or fax any NEW prescriptions.**

If a less expensive, generically equivalent drug is available for the brand prescribed, the patient or the patient's agent may choose between the generically equivalent drug and the brand prescribed:
If no choice is made, the least expensive product will be used. Generic ☐ or Brand ☐

FOR REFILL PRESCRIPTIONS (entire form must be completed each time a refill is requested):

- **Check the prescription label to verify you have refills remaining and that the prescription is not expired**
- **Please have your doctor give you a new prescription if refills or prescription have expired**

Complete All Three Columns of Information for Refills

Prescription #	Drug Name & Strength	Days Supply/Qty	Copay per Rx
		Copay Total $ =	**$0.00**

By signing below, I acknowledge I have read and understand the instructions, completed all necessary blanks above, that any important information missing may delay the filling of the prescription(s) listed on this form, and that incomplete forms may be placed in a hold file awaiting further information.

Patient Signature (required for processing): _____

Make check or money order payable to: **University Health Center - Downtown Pharmacy**

If paying by credit card, supply information at right: _____ - _____ - _____ - _____ **Credit Card Number** _____/_____ **Exp. Date** _____ **Name on Credit Card**

x_____
Signature

(Revised 11/15/06)