FAX OR ESCRIPT ALL PRESCRIPTIONS TO
iCARE RX, LLC
14447 Country Walk Dr|Miami, FL 33186

Telephone: 305-251-7414 | Fax: 305-251-3878

☐ 340B Regular ☐ PREP ☐ T&T

Clinic Name: _____

340B Eligible: ☐ Yes ☐ No

Today's Date: _____

PCP: _____

PATIENT INFORMATION (REQUIRED INFORMATION)

Patient's Last Name: First: Middle: Preferred: Birth Date: ___/___/____

Sex (Check One): ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____ Pronouns: _____

Street Address: _____ P.O. Box: _____ City, State, Zip: _____

Home Phone: _____ Emergency Contact: _____ Emergency Contact Phone: _____

Any known allergies: _____

***Please attach copy of drivers license or photo ID**
☐ **Check to Indicate Copy Attached**

CURRENT PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

PRESCRIPTION INSURANCE INFORMATION *(ATTACH FRONT & BACK OF INSURANCE CARD)*

☐ **Check to Indicate Front/Back of Insurance Card is Attached**

Policy Insurance: _____ PCN: _____ BIN: _____

Subscriber's Name: _____ Rx Group Number: _____ Patient ID: _____

Patient Relationship to Subscriber (Check One): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

DELIVERY INFORMATION *(CHECK ONE)*

☐ Patient's Address (Street Address: _____ City, State, Zip: _____)

☐ Prescriber's Address (Street Address: _____ City, State, Zip: _____)

☐ Other (Street Address: _____ City, State, Zip: _____)

ACKNOWLEDGMENT FORM *(PLEASE SIGN)*

BY SIGNING BELOW, I AUTHORIZE ICARE RX PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRACTICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM.

_____ _____

Patient/Guardian Signature *Date*

**Licensed in FL*