FAX OR ESCRIPT ALL PRESCRIPTIONS TO
PRXP OF KS
300-340 Southwest Blvd, Suite 103 | Kansas City, KS 66103

Telephone: 913-233-4973 | Fax: 913-233-4975

☐ 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: ____________)

☐ Pick up at PRXP of KS LLC

ACKNOWLEDGMENT FORM *(PLEASE SIGN)*

BY SIGNING BELOW, I AUTHORIZE PRXP OF KS LLC 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 KS and MO*