PRESCRIPTION TRANSFER REQUEST FORM

DEAR MEMBER: **MEMBER ID NUMBER:** ____________________

Welcome to the IPS Prescription Mail Service Program! Our program offers you a convenient way of obtaining your maintenance medications. To enroll in our program and place your initial order, you must complete the enclosed IPS Enrollment Form/Confidential Patient Profile, include your original written prescription(s) and return all to IPS in the enclosed envelope. If you wish to transfer any remaining refills from your previous pharmacy provider to IPS, please provide the prescription information below and send to IPS along with your Enrollment Form/Confidential Patient Form. Our IPS pharmacist will contact your previous pharmacy provider and request the transfer. If they will not honor the refill request, IPS will contact your physician to obtain a new prescription for you. In the event IPS is unable to obtain a prescription from your physician in a timely manner, we will notify you immediately.

PATIENT NAME	PREVIOUS PHARMACY & PHONE NUMBER (FAX # if Known)	RX #	MEDICATION NAME AND STRENGTH	PHYSICIAN'S NAME	PHYSICIAN'S PHONE NUMBER	FILL RX NOW? YES or NO

33381 Walker Road
PO Box 166
Avon Lake, Ohio 44012
800-233-3872 Fax: (800-893-2299)
www.ipsrx.com

Member ID Name - Printed ____________________

Member's Signature ____________________ **Date** __________

Daytime Phone Number ____________________

Evening Phone Number ____________________