HUMANA. RightSourceRx

Physician Fax Form

Patient Information

Member ID (found on Humana ID card) ________ - __

Date of Birth __ / __ / ____

Gender
- Male
- Female

First Name

Last Name

M.I.

Street Number

Street Name

Apt/Suite #

City

State

ZIP Code ____ - ____

Phone Number ___ - ___ - ____

Allergies: No Known; Aspirin; Codeine; Penicillin; Peanuts; Sulfa; Other ______________________

Prescriber Information

Prescriber First Name

Prescriber Last Name

M.I.

DEA Number

NPI Number

Street Number

Street Name

Suite #

City

State

ZIP Code ____ - ____

Phone Number ___ - ___ - ____

Fax Number ___ - ___ - ____

Prescription Information

Must be **completed**, **signed** and **faxed** from provider's office

This is not valid for CII medications.

We will dispense a 90-day supply unless quantity is otherwise noted.

	Drug Name and Strength	Directions	Quantity	# of Refills	Initial for DAW
1.					
2.					
3.					

Prescriber Signature (required) ________________________________ **Today's Date** _____ / _____ / _________

Patient Signature (optional) ____________________________________

Please fax completed form with cover sheet to *Right*SourceRx: **1-800-379-7617**

For additional Physician Fax forms, go to RightSourceRx.com

GHC 19856A 10/10

PLEASE NOTE: It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. *Right*SourceRx will dispense an FDA-approved generic equivalent whenever available, when permitted by the prescriber and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center to advise. It can take up to 48 hours to be entered into our system after your fax is received.