Teamster Retiree - Medicare Part D
Mail Order Prescription Order Form - SilverScript®

Patient Name	Patient ID # Medicare #	Patient Date of Birth
Shipping Address ☐ new address		Email Address
City, State, Zip Code		Daytime Phone
List any Chronic Medical Conditions	List any Drug Allergies	Evening Phone
		Credit Card No. Exp. Date
		Transfer Pharmacy Name & Phone (if applicable)

Are You a Resident of a Skilled Nursing Facility? (please check one) ☐ Yes ☐ No

Rx Number	Name of Drug	Strength	Generic ok?	Quantity	Days Supply	Prescribing Practitioner

I Certify the information given here is correct and authorize my pharmacy to fill the enclosed and/or listed prescriptions.

Child Resistant Cap? ☐ Yes
Please Initial ☐ No

Patient's Signature _____ Date