



PREScription DRUG AND PROVIDER FORM

Please complete and submit to allow us to provide the most accurate information.

If you have more than 10 prescriptions or providers, please submit a second form with the remaining information.

Email directly to: **Debra Bivens** at debra@insure-texas.com

PERSONAL INFORMATION

Date:

Referred by:

First Name	Last Name	Cell Phone:	Email		
Street		City	County	State	Zip Code
Birthdate:	Pharmacy Preference	Prefer Mail Order	Willing to Change for Cost Savings		
		Yes ☐ No ☐	Yes ☐ No ☐		

PREScriptions

Medication Name	Dosage	Times Per Day	Refill How Often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CURRENT PROVIDERS / PHYSICIANS

Provider Name	Provider Specialty	Location & Zip Code	Provider Phone
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CURRENT HOSPITALS / FACILITIES

Hospital Name	Hospital Specialty	Location & Zip Code	Hospital Phone
1			
2			
3			

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