535 South Broad Street
Lansdale PA 19446
Phone: 215-362-2479
Email: info@advocaterx.net

Please complete this form and mail it to info@advocaterx.net

**PATIENT INFORMATION (who the prescription is for)**

Name: _____Date of Birth:_____
Shipping
Address:_____

Phone Number:_____ Sex:_____

Allergies:_____ Health Conditions:_____

**DOCTOR INFORMATION: _____**

**PRESCRIPTION INSURANCE OR FAX COPY OF CARD**

Plan Name* & ID Number:_____ BIN NUMBER:_____

Group Number:_____ PCN NUMBER:_____

**Bill plan for this prescription**: YES / NO

**PAYMENT INFORMATION (CREDIT CARD/CHECK/ CASH ON DELIVERY)**

Name (as it appears on card):_____

Credit Card Number:_____ Expiration date:_____

**ORDER INSTRUCTIONS: SHIPPING / DELIVERY / PICKUP**

| DRUG NAME/FORM/STRENGTH | QTY | DIRECTIONS FOR USE | REFILLS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

MD SIGNATURE_____

DATE:_____