Provider Fax Form

HUMANA RightSource℠

PATIENT INFORMATION			
Name (First, Last)			Date of Birth (Month/Day/Year) / /
Address (Please do not use P.O. box) City		State	ZIP code
E-mail Address (Optional)		Daytime Phone ( )	Evening Phone ( )
Member ID Number (Copy from ID card) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐		Suffix Number – ☐☐	

ALLERGY INFORMATION

Drug Allergies:

❑ No Allergies ❑ 97 – Codeine ❑ 40 – Sulfa ❑ 4 – Aspirin ❑ 31 – Penicillin ❑ 539 – Peanuts ❑ Other: _____

PRESCRIPTION INFORMATION (Must be completed by Provider)

Must be completed and faxed from provider office:

FAX COMPLETED FORM WITH COVER SHEET TO *RIGHT*SOURCE: 1-800-379-7617

PRESCRIBER INFORMATION

Attach prescription here or complete form

Today's Date: _____ / _____ / _____

DEA #: _____

Physician's Name: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Phone #: (_____) _____

Fax: (_____) _____

MOST PRESCRIPTION DRUG PLANS COVER UP TO A 90-DAY SUPPLY, REFILLABLE UP TO ONE YEAR. FACSIMILE NOT VALID FOR CII PRESCRIPTION. VALID ONLY AT *RIGHT*SOURCE.

PRESCRIPTION INFORMATION

Medication and Strength: _____

Directions: _____

_____

Quantity: _____

Number of Refills: _____

Diagnosis: _____

X _____

Provider Signature – Substitution Permissible

IN ORDER FOR A BRAND-NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "DO NOT SUBSTITUTE" IN THE SPACE BELOW

_____

PLEASE NOTE: It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. *Right*Source 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.