www.HayatRx.com
Ph: (414) 269-2530 Ext. 2
Fx: (414) 238-0187

TRANSFER MY PRESCRIPTIONS

Name: ______________________ DOB: ____________

Address: ______________________ Phone: ____________

What type of insurance do you have? Please check the box that applies to you:

☐ State Insurance ☐ Commercial Insurance

CURRENT PHARMACY INFORMATION (If you have more than one pharmacy, please list)

Pharmacy: ______________________ Phone: ____________

Address: ______________________

Pharmacy: ______________________ Phone: ____________

Address: ______________________

Do you have any drug allergies? Please list:

____________ ____________ ____________

____________ ____________ ____________

List of medications you would like to transfer (Please attach medication list if possible):

1. ____________ 6. ____________ 11. ____________
2. ____________ 7. ____________ 12. ____________
3. ____________ 8. ____________ 13. ____________
4. ____________ 9. ____________ 14. ____________
5. ____________ 10. ____________ 15. ____________

What other free services would you like to use (Check all that applies)?

☐ Medication Therapy Management ☐ Free Prescription Delivery

☐ Simplify My Meds ☐ Medication Packaging

Name of Preparer: ______________________ Phone: ____________

Signature: ______________________ Date: ____________

Signature of Patient ______________________ Date ____________