

Prescription Request

Patient Information

Patient Name *(Required)*

Cell Phone Number *(Required)*

Date of Birth

Email

Address

City

State

Zip Code

Member ID

Group ID

BIN/IIN

PCN

Prescriber Information *(Health care provider to complete or affix a prescription for 30 day supply)*

Physician Name(s)

Phone Number

Fax Number

DEA Number

NPI Number

Prescription Information *(to be filled out by health care provider)*

- vitaPearl**TM - 1 softgel daily
- vitaTrue**[®] (Vegan/Kosher) - 1 softgel & 1 tablet daily
- vitaMedMD**[®] **RediChew**[®] **Rx** - 1 tablet daily
- vitaMedMD**[®] **One Rx** - 1 softgel daily

Quantity *(one box represents one month supply)*: _____

Number of Refills: _____

*In accordance with State regulations, a generic may be substituted unless otherwise indicated.
May be substituted with any vitaMedMD prenatal vitamin.*

Prescriber Signature: _____ Date: _____

Not valid for Medicaid or other similar federal or state programs.

Processing and fulfillment of prescription may be completed by vitaCare Prescription Services or transferred to another pharmacy based on patient's insurance and filling preference.

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