Mail order form

Please use **blue** or **black ink** to fill this form

Patient information

Name: _____

Date of birth: _____ Gender: _____

Shipping address: _____

City, State, Zip: _____

Phone: _____ Alternate phone: _____

Drug allergies: _____

_____

Primary care physician

Physician: _____ Phone: _____

Insurance information

Plan name: _____ Member ID: _____

Prescription information

Drug name and strength	Current dose	Physician name and number	Pharmacy name and number (if transferring)

469.764.1120 | **855.388.3090** Toll free | **469.764.1130** Fax
or email **MailOrderPharmacy@BSWHealth.org**

Baylor Scott & White Pharmacy cannot mail out-of-state.

Baylor Scott & White
PHARMACY

Baylor Scott & White Pharmacy #113
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