MED-CARE PHARMACY

1052 S. Powerline Rd.
Deerfield Beach, FL
Tel. 1-800-899-4852 33442 Fax 1-877-823-7505

Welcome and thank you for choosing Med-Care Pharmacy as your new prescription supplier.

In order to begin your prescription request, please use adobe acrobat to fill out the necessary information and submit your request to Med-Care Pharmacy. It's that easy!

Our trained prescription specialists will review your request and verify with you, any missing or incomplete details.

Once your prescription request has been reviewed, we will send your request to your doctor and inform you of when your prescription has been approved as well as of when your supplies will be shipping to your door.

In order to expedite your request, we ask that you please contact your doctor as soon as you submit your application and inform them of your request. Provide them with our information and let them know that you have chosen MED-CARE PHARMACY as your pharmacy. This way, your doctor will be able to approve your prescription and provide us with any needed supporting documentation without delay.

TO SUBMIT A PRESCRIPTION REQUEST (choose one):

1. Fill out the Prescription Request Form below
2. fill it out using adobe Acrobat or print and complete the request by hand
3. You can send us your request via
    a. Fax: (954) 794-0671; or
    b. Email to: prescriptionrequest@med-care.us ;or
    c. Direct mail it to:
    Med-Care Pharmacy
    1052 S. Powerline Rd.
    Deerfield Beach, FL 33442

If you have any questions or would prefer to place your request through the phone, please call

1 (800) 899 - 4852

Thank you for choosing Med-Care Pharmacy!

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Prescription Request Form

Email:

First Name, Last Name:

Phone:

Home Address:

City:

State:

Zip:

Date of Birth:

Insurance Carrier:

Insurance #:

Bin #:

PCN #:

Group #

Known Allergies:

Message to Prescription Specialist:

Doctor First Name, Last Name:

Doctor Phone:

Doctor Fax:

Doctor Address:

City:

State:

Zip:

☐ Diabetes Supplies:

Frequency of Testing:

Insulin Dependent:

☐ YES ☐ NO

☐ Prescription Medication(s):

Name of Medication(s) / Strength / Dosage

☐ Compounded Medications

☐ YES ☐ NO

☐ Other Request: