

# SBTMeds

Cortland County, N.Y.



Dependent Form

MEMBER #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL FREE TO: 1-866-715-(MEDS)6337  
OR

MAIL TO: SBTMeds, P.O. BOX 44650, DETROIT, MI., U.S.A. 48244-0650 PHONE TOLL FREE: 1-866-893-(MEDS)6337

PATIENT INFORMATION: Birthdate \_\_\_\_\_  SPOUSE  
DD/MM/YYYY  DEPENDENT

**NOTE:**

Please request a **3-month** supply of medication with **3 refills**.

**New-to-you** meds must be tried for 30 days before ordering through this program.

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

First Name (please print) \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements.	Strength	Reason for Taking	Daily Use
<i>Ex. Lipitor (This is NOT a prescription.)</i>	<i>Ex. 10 mg</i>	<i>Ex. Cholesterol</i>	<i>Ex. One a day</i>

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.)  Male  Female

(i) Operations: eg. Hysterectomy, Gall Bladder, Heart Operations, etc. \_\_\_\_\_

(ii) Hospitalization: (stays in hospital past 5 years) \_\_\_\_\_

(iii) Present Illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc. \_\_\_\_\_

(iv) Drug Allergies:  NO  YES If yes, please specify: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Signature (optional) \_\_\_\_\_ Date (DD/MM/YY) \_\_\_\_\_

**AUTHORIZATION IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18**  
I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that she/he has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read and understand the Terms of Agreement on the reverse and that the information provided above is accurate and true. I request and authorize Cortland County, N.Y., to pay for any and services, fees and amounts relating to the prescription medications that I will obtain through this service.

Parent's/Guardian's Signature \_\_\_\_\_ Date (DD/MM/YY) \_\_\_\_\_

**AUTHORIZATION IF THE PATIENT IS THE SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER**  
I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medication for a period of more than 30 days. I certify that I have read and understand the Terms of Agreement on the reverse and that the information provided by me is accurate and true. I request and authorize Cortland County, N.Y., to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Patient Signature \_\_\_\_\_ Date (DD/MM/YY) \_\_\_\_\_