

SBTMeds

Cortland County, N.Y.



Subscriber 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 _____
DD/MM/YYYY

Phone (Home) _____ Phone (Work) _____

First Name (please print) _____ Initial _____ Last Name _____

Street Address _____

City/State _____ Zip Code _____

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.

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

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 medications ordered through this program 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, NY. 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) _____