



FAX 1-844-504-3278
 PHONE 1-877-327-8881
 www.FASTACCESSRX.com

GENERAL FORM

PATIENT INFORMATION:

Patient Name: _____
 Date of Birth: _____ Male: Female:
 Address: _____
 City/State/Zip: _____
 Tel: _____ Alt Tel: _____
 SS#: _____ Wt: _____ Ht: _____
 NKDA: Allergy: _____

INSURANCE INFORMATION:

Primary Pharmacy Insurance _____
 Member Name: _____
 Member ID: _____
 Rx Group #: _____
 BIN# _____ PCN# _____
 Customer Service #: _____
Please attach a copy of the front and back of the patient's insurance card, if available.*****

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis and ICD10: _____
 Prior meds failed: _____

PRESCRIBER INFORMATION:

Prescriber Name: _____ Specialty: _____
 Address: _____ City/State/Zip: _____
 Contact Name: _____ Phone #: _____ Fax #: _____
 NPI#: _____ DEA #: _____ UPIN #: _____
 By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.
 Prescriber Printed Name: _____ Date: _____
 Prescriber Signature Below: *(Physician attests this is his/her legal signature. NO STAMPS)*

Substitution Allowed

Dispense as Written

PRESCRIPTION:

Medication	Strength	Directions	Quantity	Refills
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____