Galloway Pharmacy
Delivering the drugstore to your door.

Patient Name (Last, First) _____ Account # _____ Date _____ Account Representative _____ Source _____

PATIENT	PATIENT NAME		DATE OF SERVICE
	DOB	M ☐ F ☐	SOCIAL SECURITY #
	ADDRESS		PHONE ( )
	CITY, STATE, ZIP		
INSURANCE	MEDICARE #		
	OTHER INSURANCE		PHONE ( )
	MEMBER ID #		GROUP #
	SUBSCRIBER NAME IF OTHER THAN PATIENT		RELATIONSHIP SPOUSE ☐ CHILD ☐ OTHER ☐
PHYSICIAN	PHYSICIAN NAME		PHONE
	ADDRESS		FAX
	CITY, STATE, ZIP		
	DEA #	UPIN#	STATE LIC.#
	OFFICE CONTACT		

PHYSICIAN PRESCRIPTION FORM

Refills PRN Other _____ No Substitutions Diagnosis _____

Physician Signature _____ **Date** _____

Fax completed form to: 800.549.5553

Call Tanja at 800.546.5551 with any questions

Supplier Information
2995 National Avenue
San Diego, CA 92113
NSC:0739970001
Tax I.D.# 95-2118758