

# MAIL ORDER FORM

Please use **blue or black ink** to fill this form

PATIENT INFORMATION			
NAME			
DOB		GENDER	
SHIPPING ADDRESS			
CITY, STATE, ZIP			
PHONE			
ALT PHONE			
DRUG ALLERGIES			
PRIMARY CARE PHYSICIAN			
PHYSICIAN NAME		PHONE NUMBER	
INSURANCE INFORMATION			
PLAN NAME		MEMBER ID	
PRESCRIPTION INFORMATION			
DRUG NAME & STRENGTH	CURRENT DOSE	PHYSICIAN NAME & PHONE NUMBER	PHARMACY NAME & NUMBER (if transferring)

Mail or Fax form:

Baylor Scott & White Pharmacy #107  
 1600 West College Street  
 Suite 110  
 Grapevine, TX 76051  
 P. 817.388.3090  
 Toll Free 855.388.3090  
 F. 817.388.3091

Or email to [BHERETAILRX@BSWHealth.org](mailto:BHERETAILRX@BSWHealth.org)