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PRESCRIPTION FAX FORM

PATIENT NAME:		Lost	DOB:/
Address:			
			Phone: ()
Subscriber/Cardholder Info	rmation:	- · - ·	1
RX INSURANCE PLAN:		İ	
DV DD / //		i	TAPE
RX BIN #:		:	PRESCRIPTION
RX ID:	_	:	HERE .
		 	Please Fax the Rx to: (718) 765-9056
		or	*Don't forget to <i>mail</i> us the <i>iginal</i> prescription after you fax it over!
		<u> </u>	!

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