

Lehigh Valley Pharmacy Services Refill Transfer Form

Please submit completed form to the pharmacy when you have 7-10 days of medication remaining.

You can drop off the form at any of the pharmacies or fax to the number below:

Cedar Crest	610-402-8800	Schuylkill	570-621-4963
Muhlenberg	484-884-2969	Hazleton	570-501-4856
17th & Chew	610-969-2784		
Pocono	570-476-3645		

Patient Name	
Date of Birth	Daytime Phone Number
Street Address	City, State, Zip Code
Current Pharmacy Name	Current Pharmacy Phone Number

1	Prescription Number:	Medication Name:	Strength: _____
	Prescriber:	Prescriber's Phone Number:	Supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90
2	Prescription Number:	Medication Name:	Strength: _____
	Prescriber:	Prescriber's Phone Number:	Supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90
3	Prescription Number:	Medication Name:	Strength: _____
	Prescriber:	Prescriber's Phone Number:	Supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90
4	Prescription Number:	Medication Name:	Strength: _____
	Prescriber:	Prescriber's Phone Number:	Supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90
5	Prescription Number:	Medication Name:	Strength: _____
	Prescriber:	Prescriber's Phone Number:	Supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90

Are you currently enrolled in our Convenience Shipping program? Yes No

If 'no' and are interested in having prescription refills mailed to your home, please sign below. By signing, you are agreeing for the pharmacy to contact you at the number provided to complete the enrollment process.

Signature: _____

Date: _____