Refill Form

Please print out this form, complete
it in dark-colored ink, and fax it to
305.442.8185 or scan it and e-mail
it to cgrx1@yahoo.com.
ph: 305.442.0211
ph: 1.877.442.8702
Coconut Grove Pharmacy
3001 SW 27th Ave.
Coconut Grove, Fl 33133

1. Patient Information:

Patient Name_____
Phone (____)_____
Date of Birth____/____/_____

2. Prescription Info:

Prescription#_____

3. Retrieval Method:

Please check one of the following:

[ ] The prescription will be picked up.
[ ] Please deliver.
[ ] Please ship/mail.

Delivery/ Shipping Address (if different from address on file):

Address_____
City_____ State_____ Zip_____
Phone (____)_____

4. Billing Information:

[ ] Bill card on file.
[ ] Bill new card below:

Type of Credit Card:

[ ] Visa [ ] Mastercard [ ] Discover [ ] Amex

Name as it appears on the card:

_____
Credit Card #_____
Exp Date____/____/____
CVV2*_____

*3-digit code printed on back of MasterCard, Visa, and Discover cards.

*4-digit code printed (NOT embossed) on front of American Express card.

5. Authorization:

I authorize all prescriptions charged for amounts not covered by my insurance plan to be billed to the above charge card or my card on file.

Cardholder
Signature_____
Date____/____/____