Customer New Prescription Request

Postal Prescription Services
PO Box 2718
Portland, OR 97208-2718
Telephone: 800-552-6694
www.ppsrx.com

Patient Information

Name: _____ D.O.B.: _____ ☐ Male ☐ Female

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Patient's Preferred Phone: _____ Member ID #: _____

Allergy Information: _____ Health Conditions: _____

Prescription Information

New prescription(s) enclosed ☐

Transfer prescriptions from another pharmacy ☐

Contact doctor for new prescription(s) ☐

Prescription No.	Name of Medication	Strength	Pharmacy Name & Phone	Doctor Name & Phone

Method of Payment

Check ☐ Credit Card ☐ Money Order ☐

_____ Name as it Appears on Card

_____ Credit Card Number

_____ Exp Date (MM/YY)

Mail completed form and new prescription(s) to address on top of form. You should receive your order back in 7-10 calendar days. PPS will contact you at your preferred phone number if there is an issue in filling your prescription(s). PPS will notify you automatically when your order ships by email, text, or phone. Please select your preferred notification method by checking the appropriate box and providing the needed information.

Email: ☐ Text: ☐ Phone: ☐

_____

Thank you. We appreciate your business!