PATIENT QUESTIONAIRE

This questionnaire and the form from your insurance company must be mailed/faxed to us. You are responsible for obtaining the necessary paperwork from your insurance company and sending it to us along with this completed questionnaire. If you experience difficulty getting the necessary paperwork from your insurance company, you may want to call your employer's benefits manager and let them know about the situation. **As a reminder, we must have both of these items if you would like for us to try and get your medication authorized.**

Name_____Date of birth:_____

Ins. Company:_____ID#_____

Subscriber Name_____Group#_____

HWWC Physician:_____

Name of medication being prescribed:_____
Reason the medication is being prescribed:_____
Have you taken any other medications for this same problem?_____

If so, please list the name of the drug, dates of therapy:_____
_____

How long have you been on this medication?_____
When was this medication first prescribed?_____
What is the name of the physician who first prescribed the medication?_____
Did you receive any samples of the medication in the office?_____

List any other information that may be pertinent to this medication request that may be helpful to your insurance company:_____
_____

Do you have a prescription copay?_____ Amount:_____

I, _____ hereby certify that the above information is
Patient name

Accurate and complete to the best of my knowledge.

_____ _____
Patient's signature Date