

Medication Information Form

Complete this form & mail along with your processing fee of \$5.00 for EACH medication requested to:
The Medicine Program • P.O. Box 520, Doniphan, MO 63935-0520 • Phone: 1-573-996-7300
 Internet: <http://www.themedicineprogram.com> • e-mail: help@themedicineprogram.com

To begin the application process, complete the **Medication Information Form** and mail to us the following items:

1. The name, address and phone number of the person taking the medication(s).
2. The name of the medication(s).
3. The name and address of the doctor who prescribes the medication(s).
4. **The Medicine Program** requires a \$5.00 processing fee for EACH medication requested. It is payable to **"The Medicine Program"** and should be mailed to us along with the completed Medication Information Form.



PLEASE PRINT

"The Patient's Advocate"

Name of Patient _____

Mailing Address _____

City _____ State _____ Zip _____

Area Code/Telephone (_____) _____ Date _____

Number of Medications requested **x \$5 ea = Amount due \$** _____

Application will not be processed without the correct fee enclosed.

NAME OF MEDICATION

NAME & ADDRESS OF DOCTOR

	NAME OF MEDICATION	NAME & ADDRESS OF DOCTOR
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Please Make Copies of This Form if Needed

Available in Spanish.