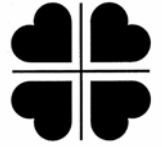




COMMUNITY CLINICAL SERVICES

Prescription Drug (340B) Program Referral Form



**Specialist's Office must complete Sections 1 and 2
and fax the form to the Primary Care Physician's (PCP) Office**

Please fill in **ALL** applicable fields prior to submission; incomplete application forms cannot be processed. Please notify patients that authorization may take up to 48 hours and that prescriptions must be dispensed at:
The Medicine Shoppe – 373 Sabattus Street – Lewiston – Phone: 783-3539 – Fax: 786-9252

Section 1 - Participant Information: *(To Be Completed by Specialist's Office)*

Patient Name (First, MI, Last)	Patient ID (SSN)	Patient Date of Birth
Street Address		M F
		Gender <i>(Circle One)</i>
City	State	Zip

NOTE: If the Patient is not previously enrolled as a CCS Patient, Enrollment Form must first be submitted. By the PCP's Office.

Section 2 – Prescription Information: *(To Be Completed by Specialist's Office)*

Specialist Physician Name: _____ Specialist Physician DEA#: _____

Drug Name	Strength	Day Supply	Number of Refills

Prescribing Specialist Physician's Signature: _____ Date: _____
(Facsimile signatures are allowed)

Once sections 1 and 2 are completed by Specialist's Office, form needs to be faxed to PCP Office

Section 3 – CCS Practice Information: *(To Be Completed by PCP's Office)*

CCS Practice Name: _____

Patient's Primary Care Physician (PCP) Name: _____

PCP acknowledges that the participant named in Section 1 is a patient of the CCS Practice as of the date below:

PCP Signature: _____ Date: _____
(Facsimile signatures are allowed)

Once all sections are complete, PCP's Office needs to fax form to GHS Data Management at 629-5121.

GHS Use Only:

Received By: _____	Date Received: _____
Status: _____	Date Entered: _____
Initials: _____	