Department of Veterans Affairs

VETERAN REQUEST FOR REFILL OF MEDICATIONS AND/OR MEDICAL SUPPLIES

Instructions: This form is for your use in requesting additional medications or supplies. Mail in at least 14 days before your supply is exhausted. Before mailing this form, please check it over to be sure all patient identification blanks have been completed. Prescriptions more than six months old cannot be refilled.

PRESCRIPTION NUMBER	NAME(S) OF MEDICATION AND/OR MEDICAL SUPPLY *(Be sure to list only current prescriptions)*

Caution - Always carefully check all medications after receiving them. If any medication appears to be different from what you have been taking, please immediately phone the Pharmacy( ) for clarification.

Please be sure that name and address are entered in the space to insure prompt delivery of medication.

PATIENT'S IDENTIFICATION *(Print or Type)*

NAME *(Last, First, Middle Initial)*	SOCIAL SECURITY NO.	DATE
NUMBER AND STREET	TELEPHONE *(Include area code)*	
CITY, STATE AND ZIP CODE	PATIENT'S SIGNATURE	

The information requested on this form is solicited under authority of Title 38, U. S. Code, Veterans' Benefits, and will be used to process your prescription in the shortest time. Disclosure is voluntary. However, if information is not furnished the processing of of your prescription may be delayed. Failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled.