

### HMC Rx Care Auto Refill Form

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please list which medications you would like on autofill  
(list name & strength or Rx #):

**Please Note:** Controlled and narcotic medications are not eligible. Patient with Medicare and Medicaid are also not eligible. If your drug therapy changes, please let us know!

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