## **HMC Rx Care Auto Refill Form**

## Patient Name: Patient Name: \_\_\_\_\_ Patient DOB: Patient DOB: Phone Number: \_\_\_\_\_ Phone Number: Please list which medications you would like on autofill Please list which medications you would like on autofill (list name & strength or Rx #): (list name & strength or Rx #): Please Note: Controlled and narcotic medications are not Please Note: Controlled and narcotic medications are not eligible. Patient with Medicare and Medicaid are also not eligible. Patient with Medicare and Medicaid are also not eligible. If your drug therapy changes, please let us know! eligible. If your drug therapy changes, please let us know! **HMC Rx Care Auto Refill Form HMC Rx Care Auto Refill Form** Patient Name: Patient Name: \_\_\_\_\_ Patient DOB: Patient DOB: Phone Number: Phone Number: Please list which medications you would like on autofill Please list which medications you would like on autofill (list name & strength or Rx #): (list name & strength or Rx #):

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