

PRESCRIPTION




NEW MEDICAL PROVIDER INTAKE FORM

PRACTICE / COMPANY			
NAME:	ADDRESS:	CITY, STATE:	DATE of BIRTH (Month / Day) ____/____/____
EMAIL:		TELEPHONE:	
WEB SITE URL:			

PROVIDER 1			
PROVIDER:	PHONE	NPI #	DEA #
OFFICE MANAGER	PHONE	OFFICE FAX	OFFICE Email

PROVIDER 2			
PROVIDER:	PHONE	NPI #	DEA #
OFFICE MANAGER	PHONE	OFFICE FAX	OFFICE Email

QUESTIONS			
1. Are the medications ordered going to be paid by?	<input type="checkbox"/> Company	<input type="checkbox"/> Patient	
2. We are shipping the order to:	<input type="checkbox"/> Provider	<input type="checkbox"/> Patient	
3. Is MILLERS permitted to contact patient?	<input type="checkbox"/> Only Provider	<input type="checkbox"/> MILLERS may contact	
4. Do you require signature of patient for shipments of controlled substances (charge applies)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Did you approve the pricing sheet provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. On controlled substance, You agree that you will do PMP and other appropriate background checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. You agree that you have represented to MILLERS that it can rely on such information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

PAYMENT INFORMATION			
NAME:			
BILLING ADDRESS: (If different than mailing address)			
TYPE:	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 
	<input type="checkbox"/> OTHER		
CARD #	EXPIRATION DATE:	SECURITY CODE:	

ACH TRANSACTION			
BANK:	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS ABA	ROUTING #
			ACCOUNT #

AGREED PRICING/NOTES	

PROVIDER:	PHONE	EMAIL:
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SIGNATURE:	DATE (Month / Day / Year) ____/____/____
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