PDP Team Referral Form

Date:	

Beneficiary Name, DOB and Last 4 digits of SS#

Reason for Referral:

	Dose:	& Amt.of Per Day:

Name and Phone # of Pharmacy using to obtain Emergency P

Are the Prescription(s) on file at the Pharmacy?

Additional Information (steps which SHIP worker took in reso

T/c with client to resolve drug co-pay billing issues.

SHIP Staff Name:

SHIP Referral Phone#

AHS.DVHAPDPTeam@Vermont.gov

New or Refill Script:

rescription(s):

lving the case):