PDP Team Referral Form

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Date:	

Beneficiary Name, DOB and Last 4 digits of SS#

Reason for Referral:	

	Dose:	**& Amt.of Per Day:**	**New or Refill Script:**

Name and Phone # of Pharmacy using to obtain Emergency Prescription(s):

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

Additional Information (steps which SHIP worker took in resolving the case):
T/c with client to resolve drug co-pay billing issues.

SHIP Staff Name:
SHIP Referral Phone#