Maria I. Betancourt MD, PLLC

Prescription Refill Request Date: _____

Patient: _____

Date of Birth: _____

Date of Last Visit or Next Appt _____

Home Phone: _____

Work Phone: _____

Provider Name: _____

Name of Medication: _____

Dosage/Directions: _____

Number of Refills: _____

Pharmacy Information: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

For Office Use Only

Approved or Denied: _____

Reason for Denial: _____

Completed by: _____

Date Completed: _____