HEALTH INFORMATION DESIGNS, INC
PRESCRIPTION DRUG MONITORING PROGRAM
PDM-UNIVERSAL CLAIM FORM

SC UGF – SINGLE DRUG CLAIM FORM		**DATE:**
PHARMACY INFORMATION		
PHARMACY NAME:	DEA:	
PHONE:	FAX:	
ADDRESS:	CITY/STATE/ZIP:	
PRESCRIPTION INFORMATION		
NDC:	DRUG NAME/STRENGTH:	
QUANTITY DISPENSED:	DAYS SUPPLY:	REFILLS LEFT:
PRESCRIBER NAME:		DEA:

PATIENT INFORMATION

DATE DISPENSED	NAME (LAST, FIRST, M.I.)	DOB	GENDER	ADDRESS
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Fax completed form to 1 866 422 3761