MBs Pharma Care

Always there to care

MBs Pharma Care goal is to satisfy our patient pharmacy needs with the highest quality care and insure that physicians, nurses, and other healthcare professionals have a partner they can depend on.

Why MBs Pharma Care?

- Experienced pharmacists and staff in long-term care services.
- **FREE OF CHARGE** customized delivery options to fit your needs.
- State of the art IVR patient reminder/refill system, E-prescription, telephone, fax and mail.
- On-call pharmacists accessible to answer all your questions.
- **FREE OF CHARGE** multiple packaging options (vials, unit dose blister packs, multi-dose, ...etc).
- Immunization, MTMs and patient consultation services.
- **FREE OF CHARGE** Patient-friendly compliance packaging (Dispill cards).

Simply, We'll do our level best to satisfy your needs and minimize your cost.

To transfer your prescriptions to **MBs Pharma Care** is quick and easy! Just follow the 3 below simple steps and we'll do the rest:

- Complete and sign the **Prescription Transfer Order Form** (2 pages).
- Copy both sides of your **Prescription Insurance Card.**
- Fax all above to us at **508-372-1607.**

Thanks for choosing MBs Pharma Care. We'll always be there to care..

MBs Pharma Care Team

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Prescription Transfer Order Form

Patient Information:

Name: _____ Date of Birth: _____

Resident in (Facility/Apt.#):___ _____

Address: _____ City: _____ State: _____ Zip: _____

Rx Insurance Information: *Please attach a copy of the insurance card*

Insurer Name:_____ Relationship to Policyholder: _____

ID Number: _____ Rx Bin: _____ PCN: _____ Group: _____

Medicare ID Number: _____

Originating Pharmacy *Please tell us where you fill your prescriptions today:*

Pharmacy Name: _____ City: _____ Phone: _____

Family Contact Information:

Name: _____ Relation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Payment:

Pay By Credit Card:

I authorize MBS Pharma Care to charge my credit card on file before delivery with any charges due.

Signature: _____ **Date:** _____

By completing and submitting this form, I understand that I'm requesting enrollment in MBS Pharma Care delivery. I agree to notify MBS Pharma Care of any changes that may occur to any prescription enrolled in this form. I understand that MBS Pharma Care will deliver my medications to the primary address on file unless otherwise indicated.

1035 B Providence Rd. Whitinsville MA 01588
Tel: 508 372 0627 Fax: 508 372 1607

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Prescription Transfer Order Form

Prescriptions Information:

Allergies: _____

_____

Drug Name & Strength	Dosing Times	Doctor Name	Doctor Phone Number

More prescriptions: Yes ☐ No ☐ If Yes, please use the back side of this form.

Automatic Refills: Yes ☐ No ☐

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