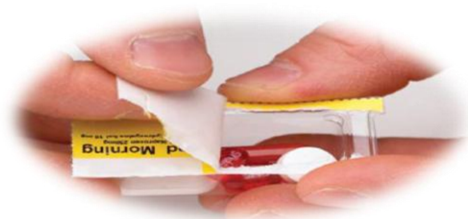
MBs Pharma Care
Always there to care

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

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 (Billing):

Name: ____ Relation: ___________________________

Address: _________________________________ City: __________ State: _________ Zip: __________

Phone: ___________________________ Email: ____

Payment Options :

☐ **Pay By Credit Card:**

I authorize MBS Pharma Care to charge my complete outstanding balance to below credit card:

Card Type: ____________ Card # ____ CCV:__________

Name on Card: ____Expiration Date: __ __ / __ __

☐ **Pay By Check:**

I agree to pay my complete outstanding balance, as shown on the statement.

Signature: _________________________________ **Date:** ________________________

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

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Prescription Transfer Order Form

Patient Information:

Name: ____ Date of Birth: ___________________________

Allergies: ____

Drug Name & Strength	Dosing Times	Directions

More prescriptions: Yes☐ No☐ If Yes, please use additional sheet.

Automatic Refills: Yes ☐ No ☐ **Refillable until:** _______ (Good for 1 year unless otherwise indicated)

For CII-CV medications: Separate written prescriptions are required.

Doctor Name:____ **Signature:** ___________________________

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