

Alternate Delivery of Medication(s) (Ship to Home)

Medication is **dispensed** by: VDH Pharmacy Services Local Health Department

Program: _____

Billing Information: *If VA MAP (ADAP), may leave blank. If unsure of coding for other programs, consult the district business manager.*

Cost Code: _____ FIPS: _____ PSD: _____

Medication is **shipped** by: VDH Pharmacy Services Local Health Department
** denotes required fields if shipped by pharmacy*

* Health Department Site: _____

* Contact Person: _____

* Contact Phone Number: _____

* Fax Number: _____

Client Name: _____ **Date of Birth:** _____

Shipping Address:

** No Postal Box may be used if shipped by VDH Pharmacy Services.*

City

State

Zip Code

Note:
Pharmacy will utilize United Parcel Service (UPS) as the courier.

If address listed is not a UPS deliverable address, pharmacy will make contact person aware.

Client Phone Number: _____

Note: *Signature may be required by the courier in order to leave package.*

Medication(s) Requested to be Shipped to Address Above:

Date Shipped: _____ Tracking info: _____

Date received: _____

If you have a copy of the dispensing label, please affix to the back of this form.

Copy of Medication Labels:

*Copy of label affixed
to the medication
that was shipped*

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to the medication
that was shipped*

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