Request for Alternate Delivery of Medications (Ship to Home)

Program: ☐ TB ☐ FP ☐ STI ☐ MCH ☐ VA MAP

Billing Information of Health Dept.: Cost Code _____ FIPS_____ PSD_____
*If unsure of coding, consult the district business manager. Billing information not required for VA MAP.

Note: For VA MAP, 'health department' is the medication access site which could be non-health departments like clinics and pharmacies that serve as pick up sites.

Health Department Site: _____

Contact Person: _____

Contact Phone #:_____

Fax #: _____

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

Shipping Address:

_____

Note: United Parcel Service (UPS) will be Courier. No Postal Boxes accepted.

_____
City State Zip Code

☐ **Current client address has been verified Date:** _____

Client Phone #: _____

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

_____

_____

_____

_____

_____

Information below for Pharmacy to Complete and Fax back to Health Department Fax Listed Above:

Tracking #: _____

Shipping Cost: _____ **Date Received:** _____

Last Revised: 10/01/2020