FAX: 334-448-9918

ALABAMA MED RX FORM

Patient Number

DATE OF SERVICE:_____ Provider # _____

Provider Name:_____

Provider Address:_____

City:_____State:_____Zip:_____

PROVIDER SIGNATURE:_____

RECIPIENT

PT. NAME: _____

DOB:___/____/_____ PHONE #_(____)_____-_____ CELL:_(____)_____-_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

Recipient Number

Prior Authorization

_____

FRAME NAME		COLOR	
SIZE:			

Circle One	LENS TYPE			P.D.	SEG HT.
SV	FT-28	RD 24	Progressive		
CR 39	7x25	Poly			

	SPH	CYL.	AX	ADD	PRISM	BASE
OD						
	SPH	CYL.	AX	ADD	PRISM	BASE
OS						
	SENT		DATE REC		DATE SHIP	

SPECIAL INSTRUCTIONS: _____

- ☐ S R C _____ _____
- ☐ A R _____ _____
- ☐ P-C GREY _____ _____
- ☐ TINT _____ _____