MILLIKEN MEDICAL PRESCRIPTION REFILL FORM

Full Legal Name:_____

Date of Birth:_____

Physician:_____

Home Phone:_____ **Cell Phone**:_____

Prescriptions Needed:

Name of Medication	Dose	Frequency

Preferred Pharmacy:

_____

Name Address Phone #

Please complete this form in its entirety and Fax to (231) 935-0613

If you have any questions, please call our prescription line at (231) 932-4920

Please allow 24 to 48 hours for all prescription refill requests.