

ePostRx System Administrator

Store Hours:

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A520



Exception Id: 1549

Order Number: 713

Attention Doctor DR. DOCTOR TEST

Fax back to _____ **or Call +256 (111) 333-** _____ **to speak with a pharmacist**

The following prescription(s) cannot be filled for the reason(s) listed below. Please review very carefully and make any necessary changes per your patient records. Please sign the bottom of the form and return to us.

Patient name	<u>WIRE,BRENDA</u>	DOB	<u>09/04/1958</u>
Patient	<u>17 BROOKDALE DRIVE NEW BRITAIN PA</u>	MPI	<u>81</u>
	<u>18901 USA</u>	Phone	<u>(267) 252-0487</u>

Drug Description	Directions	Qty	Request Reason	Refills
KERALAC GEL 50 %	AS DIRECTED	20	CONTACT INFORMATION MISSING	5

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Comments

[Empty box for comments]

Dr. Signature _____

Date _____

DR. DOCTOR TEST

Below ID numbers are needed for most insurance billing. Please complete/verify the information below:

License #	DEA #	AT1111169	Fax	(800) 123-4567
Medicaid ID #	NPI #	12346	Phone	(215) 555-2121