PATIENT ASSISTANCE PROGRAM NOTIFICATION FORM

Plan/Medical Group Name: My Health LA Plan/Medical Group Fax#: 310-669-5609

Instructions: The intent of this document is to notify DHS Central Pharmacy of existing patients who are currently taking medications through Patient Assistance Programs (PAP). Please fill out all applicable sections completely and legibly. Please forward this form to Department of Health Services Central Pharmacy for medication reconciliation VIA FAX 310-669-5609 or email PRIORAUTH@DHS.LACOUNTY.GOV.

Patient Information: This must be filled out completely to ensure HIPAA compliance					
First Name:	Last Name:	MI:	MHLA PID #:		
Address:		City:	State:	Zip Code:	
DOB:	Male Female	Phone#:			
Patient's Authorized Representative (if applicable):		Authorized Representative Phone#:			

Dispenser Information			
Dispenser (Pharmacy or Dispensary) Name:		NPI:	
Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

PAP Medication 1			
Manufacturer:	NDC:	Medication Name and Form:	Dose/Strength:
Quantity:	Date Initiated:	Directions to Use:	

Prescriber Information		
First Name:	Last Name:	NPI:
Office Phone Number:	Fax:	Email:

PAP Medication 2			
Manufacturer:	NDC:	Medication Name and Form:	Dose/Strength:
Quantity:	Date Initiated:	Directions to Use:	

Prescriber Information		
First Name:	Last Name:	NPI:
Office Phone Number:	Fax:	Email: