Appendix K

Refusal to Fill Form

Provider Information

Provider Name _____ Provider Number _____

Refusal Date _____ Pharmacist _____

Prescription Information (original or copy of prescription must be attached to this form)

Beneficiary Name _____ NLPDP Card Number _____

Medication Prescribed _____ Quantity of Medication _____

Directions _____ Date of Prescription _____

Prescribing Physician _____ Physician License Number _____

Reason for Refusal

_____

_____

_____

_____

_____

_____

_____

Physician Notified _____ YES _____ NO

Authorities (Police) Notified _____ YES _____ NO

Signature _____ Date _____