GlobalHealth Transition of Care Request Form - Prescriptions
Please complete and fax back to 405-280-5613
or mail to **GlobalHealth Pharmacy Dept. | PO Box 1747 | Oklahoma City, OK 73101-1747**

Please complete this form if you are taking prescription medications that are currently covered by another insurance company. This is necessary, even if your current doctor and pharmacy are in GlobalHealth's network. Please complete a separate form for each patient.Photocopies of this form are acceptable. **THIS FORM IS NOT INTENDED FOR USE BY GENERATIONS MEMBERS.**

INSURANCE INFORMATION		
Subscriber's Name		Subscriber's Date of Birth
Street Address		Subscriber's Member ID #
City	Zip Code	Subscriber's Group #
Date of Enrollment in GlobalHealth Benefit Plan (mm/dd/yyyy)		Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Legal Representative
Home Telephone #		If anyone other than Subscriber is completing form, please provide name and relationship to subscriber.
Mobile Telephone #		

Please provide as much information as possible about the physician(s) who prescribe these medications for you.

PHYSICIAN INFORMATION		
Physician Name		Physician's Telephone #
Physician's Practice Address		Physician's Fax #
City	Zip Code	Treatment start date

PRESCRIPTION DRUG INFORMATION		
Drug Name		Drug Strength
Quantity	Day Supply	Date of last fill
Diagnosis *(If unknown leave blank)*		Do you require Brand Name to be dispensed? ☐ Yes ☐ No

I hereby authorize the above physician(s) to provide GlobalHealth or any affiliated GlobalHealth company with any and all informationand medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. This authorization will expire 24 months from the date signed. I understand I may revoke this authorization atany time by writing to the address listed at the top of this form. I understand that I cannot restrict information that mayhave already been shared based on this authorization. I understand I am entitled to a copy of this authorization form.

Signature of subscriber, parent, or legal representative Date