57 Howard Avenue | Cranston, RI 02920 | Phone: 401.462.5274 | Fax: 401.462.3677

RI ADAP PROGRAM
MEDICAID DIVISION, HIV PROVISION OF CARE

EARLY REFILL OVERRIDE FORM FOR LOST OR STOLEN PRESCRIPTIONS

Date: ________________

Name: ____

RX Number: ____

Medication: ____

Date of last fill: ____

Prescription was: (circle one) lost stolen

If stolen, was a police report filed? (circle one) yes no

Was prescriber notified: (circle one) yes no

I hereby state that the above information is correct and I am requesting the EOHHS RI ADAP PROGRAM to authorize payment for an early refill of my lost/stolen medication.

____
(recipient signature)

____
(case manager signature)

This form must be kept on file and be made available for auditing purposes.