EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

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 Executive Office of Health and Human Services to authorize payment for an early refill of my lost/stolen medication.

_____
(Recipient signature)

_____
(Pharmacist signature)

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