Direct Phone: 940-220-5871 opt. 1
Main Phone: 940-484-4400
Secure Fax: 940-898-1986

EnBrace HR®/EnLyte® Softgel Prescription Form

1. PATIENT INFORMATION

Patient Name ____________________
Address ____________________
Apt. __________
City, State, ZIP ____________________
Home Phone __________ Alternate Phone __________
DOB __________ Gender: __________
Language Preference: ◯ English ◯ Spanish ◯ Other __________

2. PRESCRIBER INFORMATION

Prescriber's Name ____________________
DEA ____________________
NPI ____________________
Address ____________________
City, State, ZIP ____________________
Phone __________ Fax __________
Contact Person __________ Phone __________

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Prescription Card: Name of Insurer __________ ID # __________ BIN __________ PCN __________ Group __________

Primary Insurance: Subscriber __________ ID # __________ Name of Insurer __________ Phone __________

Secondary Insurance: Subscriber __________ ID # __________ Name of Insurer __________ Phone __________

4. 6;39@AE;E 3@6 5>;@;53>;@8AD? 3F;A@

Please list all current medications: ____________________

Please list all known drug allergies: ____________________

5. PRESCRIPTION INFORMATION

Medication/Dose/Strength	Directions	Quantity	Refills
EnBrace HR or EnLyte softgels	Take 1 softgel by mouth once daily	#30 softgels	

Ship to: ◯ Office ◯ Patient

6. PRESCRIBER SIGNATURE - *stamped signatures are **NOT** permitted*

X ____________________ / /
DISPENSE AS WRITTEN DATE

X ____________________ / /
PRODUCT SUBSTITUTION PERMITTED DATE

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