



# Medication reconciliation form

Patient name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Name of primary physician (doctor): \_\_\_\_\_ Phone: \_\_\_\_\_

Name of retail pharmacy (drug store): \_\_\_\_\_ Phone: \_\_\_\_\_

Known allergies and/or reactions: \_\_\_\_\_

Medication	Frequency, route	Indication	Comments	Prescribing physician



### Questions?

For member questions, please ask the member to call the Customer Service number on their member ID card.

