Surescript Forms

Please fill out the following two forms:

1) Surescripts
2) Provider Demographics

When complete email the forms to:

ITAmbulatoryserv@regionalonehealth.org

Regional One Health

The Nation's E-Prescription Network

Section I: Prescriber Information

*Prescriber First & Last Name:

Practice/Clinic Name:

Regional One Health

*Practice Address:

880 Madison Avenue

Memphis, TN 38103

*Phone Number:

(901) 545 — 6969

*Fax Number:

( ) —

*NPI Number:

*DEA Number:

NA

*Surescripts Case Number:

Fill out ONLY if you have been previously enrolled in Surescripts

*Effective Date: ____ / ____ / ____

*Authorized By: (Sign & Print)

By signing the above I hereby certify that I am authorized by the prescribing physician to make changes on their behalf.

Please allow up to 48 hours for your request to be completed.

Please email forms to ITAmbulatoryServ@regionalonehealth.org

Regional One Health

Provider Demographics Sheet

*Last Name	
*First Name	
*Credentials	
*Specialty	
*Provider Role	☐ Resident ☐ Fellow
Attending Provider (if Resident, Fellow or PharmD)	
Rotation Days	
Start Date	
*End Date	
*NPI	
*DEA	
*Email Address	

*indicates required item

Sign your name in box below. ***Make sure it is does not go outside or touch the lines.***