Good Life Resources,™ Inc.
18653 Ventura Blvd, Suite 139
Tarzana, Ca. 91356-4147

Pharmacy Service - Patient Referral Form

Please fax this form to:

Fax
(818) 705-5533

|We Make Everything Easier|

We'll gladly accept your Patient Profile Sheet as a substitute to this form.

If you prefer to speak to a representative, please call (800) 227-2111 or (818) 906-3344

To use our secure online form, click "Sign-Up" at www.goodliferesources.com

|Note|

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Referral Information

Name / Title ____________________ Date ____________

Dr's Office / Hospital ____________________

Email ____________________

Patient Information

Name ____________________ Date of Birth ____________

Street ____________________ Email ____________

City ____________ State ______ Zip ______

Phone ( ) ________ Work ( ) ________ Cell ( ) ________

Diagnosis ____________________ Date of Surgery (If Applicable) ____________

Insurance Information

Name of Policyholder ____________________ Date of Birth ____________

Insurance Company ____________________ Phone ( ) ____________

ID # ____________ Group # ____________ Plan Type (e.g. PPO) ____________

Rx Card # ____________________ Phone ( ) ____________

Employer ____________________ Phone ( ) ____________

Medicare? ❒ Yes ❒ No If Yes, Part ❒ A ❒ B ❒ C ❒ D (Check all that apply)

Physician Information

Physician Name ____________________ Phone ( ) ____________

Notes: