Uniform New Jersey Prescription Blanks Order Form

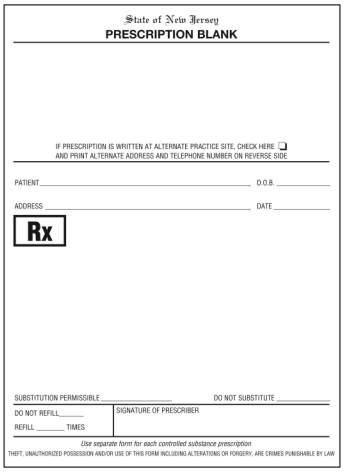
CUSTOMER INFORMATION		FOR INTERNAL USE ONLY	
COMPANY NAME		COMPANY NAME	
STREET ADDRESS (REQUIRED FOR UPS SHIPMENT)		STREET ADDRESS (REQUIRED FOR UPS SHIPMENT)	
CITY, STATE AND ZIP		CITY, STATE AND ZIP	
PHONE NUMBER (INCLUDE AREA CODE) ( )	FAX NUMBER (INCLUDE AREA CODE) ( )	PHONE NUMBER (INCLUDE AREA CODE) ( )	FAX NUMBER (INCLUDE AREA CODE) ( )
SIGNATURE OF PURCHASER	EMAIL ADDRESS	SIGNATURE OF PURCHASER	EMAIL ADDRESS

Ordering Instructions:

1. Per state requirements, all orders and reorders for Uniform New Jersey Prescription Blanks must be submitted in writing via mail or fax.
2. Use one Order Form per prescription order. Multiple prescriber names and one address may be printed on the front of each prescription. Additional addresses may be printed on the back for an additional cost.
3. The address used for shipping must match with the listing of authorized prescribers and health care facilities on file with the licensing board.
4. License numbers must be provided for each prescriber or facility.
5. The signature of each authorized prescriber or health care facility representative must be provided with each order.

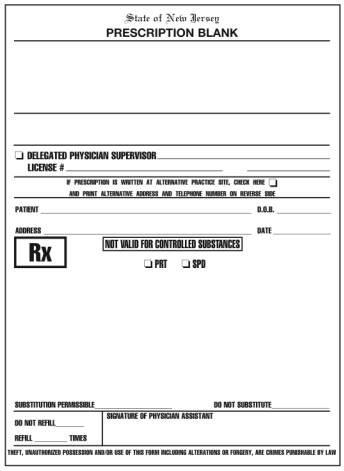
ORDERING INFORMATION: Please Check One

Healthcare



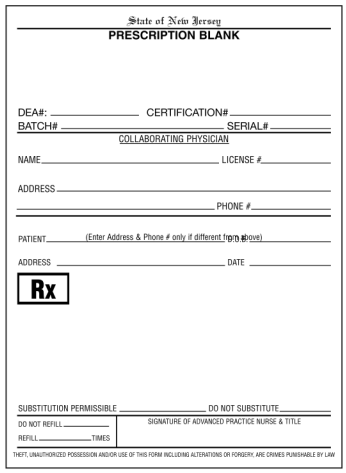
MD, DO, DDS, DMD, DPM, DVM, VMD, MVSc

445821 1-Part
445821B 1-Part, Alternate Address
445821-2 2-Part
445821B-2 2-Part, Alternate Address



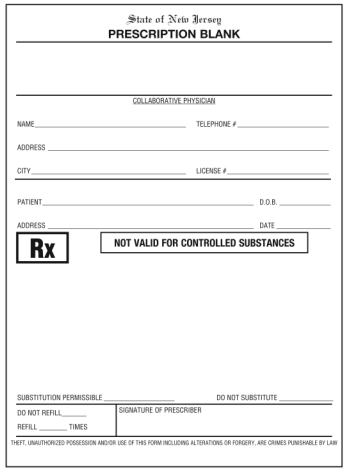
Physician Assistant

7823 1-Part
7823B 1-Part, Alternate Address
__ 7820 2-Part
7820B 2-Part, Alternate Address



Advanced Practice Nurse

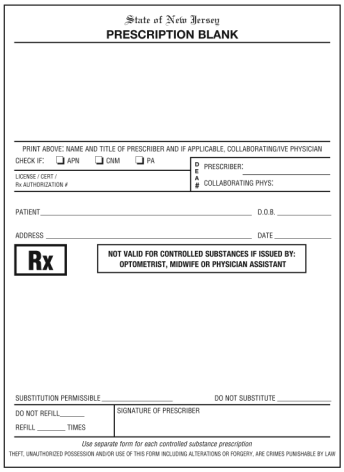
__ 445801 1-Part
445801B 1-Part, Alternate Address
445801-2 2-Part
445801B-2 2-Part, Alternate Address



Certified Nurse Midwife

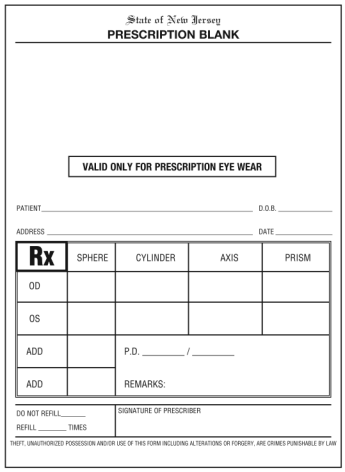
__ 445811 1-Part
445811B 1-Part, Alternate Address
445811-2 2-Part
445811B-2 2-Part, Alternate Address

Optometrist



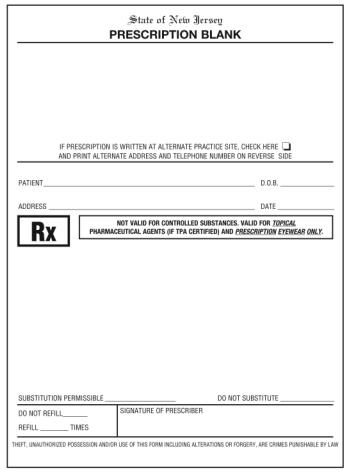
Health Care Facility

445831 1-Part
__ 445831B 1-Part, Alternate Address
445831-2 2-Part
445831B-2 2-Part, Alternate Address



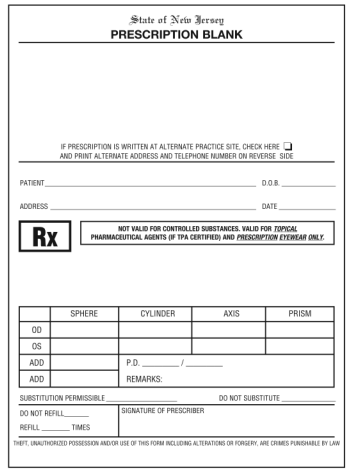
For Exclusive Use When Prescribing Eyewear

445861 1-Part
445861B 1-Part, Alternate Address
445861-2 2-Part
__ 445861B-2 2-Part, Alternate Address



Optometrists (without eyewear box)

__ 445841 1-Part
445841B 1-Part, Alternate Address
445841-2 2-Part
445841B-2 2-Part, Alternate Address
Check for contact lens warning



Optometrists (with eyewear box)

445851 1-Part
445851B 1-Part, Alternate Address
445851-2 2-Part
445851B-2 2-Part, Alternate Address
Check for contact lens warning

PRICING: Please Check One (Prices subject to change without notice.)

1-Part Pads *(100 blanks per pad)*

5 pads (500 blanks)	10 pads (1000 blanks)	20 pads (2000 blanks)	30 pads (3000 blanks)	40 pads (4000 blanks)	50 pads (5000 blanks)	100 pads (10,000 blanks)

1-Part Pads with Alternate Address *(100 blanks per pad)*

5 pads (500 blanks)	10 pads (1000 blanks)	20 pads (2000 blanks)	30 pads (3000 blanks)	40 pads (4000 blanks)	50 pads (5000 blanks)	100 pads (10,000 blanks)

2-Part Carbonless Pads *(50 sets per pad)*

10 pads (500 sets)	20 pads (1000 sets)	40 pads (2000 sets)	60 pads (3000 sets)	80 pads (4000 sets)	100 pads (5000 sets)	200 pads (10,000 sets)

2-Part Carbonless Pads with Alternate Address *(50 sets per pad)*

10 pads (500 sets)	20 pads (1000 sets)	40 pads (2000 sets)	60 pads (3000 sets)	80 pads (4000 sets)	100 pads (5000 sets)	200 pads (10,000 sets)

Check here for Consecutive Numbering *(optional)*.

Starting #: _____

Subtotal	
Add appropriate Sales Tax* *We are required to charge sales tax based on your state regulations.	
TOTAL	

Information to be printed on Prescription Blank:

1. Practice or Facility Name (if to be printed): _____
2. Prescriber Name: _____ Degree: _____
3. Practice or Specialty (only if to be printed on pads below prescriber name(s)): _____ License # _____

   Address to be printed on front: _____ STREET ADDRESS

   _____ CITY National Provider Identifier # (NPI #): _____

   Telephone # to be printed: _____ Fax # (if to be printed): _____
4. Specify if Applicable: DEA# _____ TPA Cert # _____
   (If DEA # is not provided, a blank line will be printed to be filled in by prescriber where applicable.) (For Opto, must be printed.)

   Facility Provider # _____ Certification # _____

********** **Needed each time order is placed** **********

Prescriber Signature: _____

IMPORTANT: If more than one prescriber is listed on the same blank, one of the prescribers is to be responsible for the shipment. That person must sign below:

_____

PLEASE NOTE: *By signing, you are the responsible party for this shipment of prescription blanks. Please make certain that the ship to address given below is the same as it appears with your medical licensing board.*

Optional: Additional doctors to be printed on the same prescription blank (or one collaborating physician if ordering pads for Nurse Practitioner/Certified Nurse Midwife/Physician Assistant):

1. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA#: _____ NPI #: _____

   ***Prescriber Signature:** _____

2. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA#: _____ NPI #: _____

   ***Prescriber Signature:** _____

3. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA#: _____ NPI #: _____

   ***Prescriber Signature:** _____

4. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA#: _____ NPI #: _____

   ***Prescriber Signature:** _____

Optional: Additional addresses to be printed on the back of the prescription blanks (must include phone number):
If additional addresses are required, attach separate sheet (up to 4 addresses).

Street: _____

City, State, Zip: _____

Phone: ( )

Street: _____

City, State, Zip: _____

Phone: ( )

Bill To:

Practice Name _____

Address _____ Room/Suite/Bldg. _____

City _____ State _____ Zip _____

Attention _____ Phone _____

Ship To: *Official address on file with the State Board*

Practice Name _____

Address _____ Room/Suite/Bldg. _____

City _____ State _____ Zip _____

Attention _____ Phone _____

For Reorders – Attach a sample of original Prescription Blank for faster processing.