MedWatch Patient Information Request Form

Prescribers must fax a completed MedWatch Patient Information Request Form and FDA MedWatch Form to Summit Community Care at 1-844-429-7761.

FDA MedWatch Form is available at: http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

All fields are required to be populated in order to process the request.

Patient Information

LAST NAME: | | | | | | | | | | | | |

FIRST NAME: | | | | | | | | | | | | | | | |

MEDICAID ID NUMBER: | | | | | | | | | | |

DATE OF BIRTH: | | | – | | | – | | | | |

Prescriber Information

LAST NAME: | | | | | | | | | | | | |

FIRST NAME: | | | | | | | | | | | | | | | |

NPI NUMBER: | | | | | | | | | | |

DEA NUMBER: | | | | | | | | | |

PHONE NUMBER: | | | – | | | | – | | | | |

FAX NUMBER: | | | – | | | | – | | | | |

BRAND NAME OF DRUG: _____ **STRENGTH:** _____

COMPLETED MED WATCH FORM ATTACHED?: ☐ Yes ☐ No

Prescriber Signature (Required) _____ ***Date*** _____

Prescriber's original signature required; copied, stamped, or e-signature are not allowed.

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)