

Member's  
Name: \_\_\_\_\_  
Social  
Security No.: \_\_\_\_\_  
Sponsor No.  
(From NPA  
Rx Card): \_\_\_\_\_  
Home  
Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_  
Work Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_  
Doctor's  
Name: \_\_\_\_\_  
Doctor's  
Phone No: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Name: \_\_\_\_\_  
Apt. #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Zip: \_\_\_\_\_

Check here if you do not want a "Safety  
Cap" container.  
Check here if you do not want a generic.

The law permits pharmacists to substitute a less expensive generically equivalent drug for a brand name drug, unless you or your physician direct otherwise. Your prescription will be filled generically unless you direct otherwise. Remember to enclose the copayment for each prescription, if applicable.  
**Signed:**

Make check payable to CFI or:  
Please circle your credit card type.

Card Type:	Master Card/VISA/DISCOVER
No:	
Exp. Date:	
Signed:	

Insert refill slip or fill out this section - For NEW prescription (Use separate piece of paper if necessary)

No. of Rx's enclosed	Patient Name*	Relationship (member/spouse/child)	Birthdate	Please describe below any allergies, chronic diseases or drug sensitivities you have.

This section - for REFILL prescriptions (Use separate piece of paper if necessary)

Rx Number	Patient Name*	Doctor's Name	Drug Name

\* Include last names, if they are not the same as the subscribers.

**PLEASE DO NOT WRITE BELOW THIS AREA**

1. Print form
2. Fill in information
3. Attach new prescriptions

4. Enclose any necessary Co-Pay. CFI accepts VISA, Mastercard , or Discover. Checks can be made out to CFI

5. Please contact us at [orders@NPANET.com](mailto:orders@NPANET.com), if you are not sure which CFI facility to use.

CFI

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Harrisburg, PA 17106-9301

CFI

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