

DRUG AUTHORIZATION FORM

Please fill out and mail it to: SHS. Select Health Services, 560 People's Plaza # 193, Newark, DE 19702 or fax to: (504) 737-4500 / (866) 822-4500

Account Number: _____

Name of Company: _____

Attn: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **E-mail Address:** _____

Dear SHS, Select Health Services Customer:

In order to sell and ship prescription pharmaceuticals to you, we must receive authorization from the responsible physician at your place of business or service.

Please have the authorizing physician complete this form and return it to us, along with a copy of his/her DEA registration or state license.

If your facility does not have a Medical Director, but is licensed to purchase prescription products, please send us a copy of your license along with this letter for identification.

Thank you,
SHS, Select Health Services LLC

I hereby authorize the following internally designated representative(s) of this facility to order prescription substances. **Please identify here:** _____

Unlimited Authorization

Limited Authorization

Physician's Signature: _____

Physician's Name (Please Print) _____

Choose one:

DEA Registration Number*
(For validation purposes only) *Copy Required

State License Number*
*Copy Required

_____ Exp. Date: _____

_____ Exp. Date: _____
