Medication reconciliation form

Patient name: ______________________ Birthdate: ______________

Phone: ______________________ Date: ______________

Name of primary physician (doctor): ______________________ Phone: ______________

Name of retail pharmacy (drug store): ______________________ Phone: ______________

Known allergies and/or reactions: ______________________________

Medication	Frequency, route	Indication	Comments	Prescribing physician

Questions?

For member questions, please ask the member to call the Customer Service number on their member ID card.

United Healthcare

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