FACSIMILE TRANSMISSION

CenterWell Pharmacy Mail Delivery

DATE AND TIME:	2/23/2026 9:00:25 AM
ATTENTION:	RightSourceRx LINDA GIACOBBE
COMPANY:	
FAX:	9725329272
PHONE:	9048864886
SENDER:	**CenterWell Pharmacy™ Mail Delivery**
SENDER PHONE:	**800-967-9830**
SENDER FAX:	**877-207-0198**
NUMBER OF PAGES: (INCLUDING THIS COVER)	**Two**

If this transmission is not received in good order, please call the sender at the phone number above or advise by fax to the sender's fax number above.

CenterWell Pharmacy

CenterWell Pharmacy

Phone: **800-967-9830**
Fax: **877-207-0198**

New prescription request

Your patient has requested we contact you to have their prescription(s) filled with CenterWell Pharmacy Mail Delivery. Please review and complete the information to the right.

Date faxed: 2/23/2026 9:00:27 AM
Prescriber name: RightSourceRx LINDA GIACOBBE
Prescriber phone number: 9048864886
Prescriber fax number: 9725329272
Prescriber address:
4609 HWY 17, SUITE 1

FLEMING ISLAND, FL 32003

Send this prescription electronically (eRx) by selecting "CenterWell Pharmacy Mail Delivery" (National Council for Prescription Drug Programs ID number 0353108) from the list of pharmacies on your e-prescribing tool. For additional physician fax forms, go to CenterWellPharmacy.com.

To avoid delays in processing this order, please provide strength, directions, quantity and refills for each medication listed to the right. If no quantity is entered, we will dispense up to a 100-day supply unless otherwise noted, considering some states may require prescribing a 100-day quantity in order to fill for a 100-day supply. Restrictions based on plan benefits or state/federal regulations will be taken into account.

To require that a brand-name product be dispensed, the prescriber must handwrite "brand medically necessary." If left blank, an approved substitution will be made when available.

It can take up to 48 hours for the prescription to be entered into our system after we receive your response.

Please e-prescribe (where required by state/federal regulations) or fax your response with a secure cover sheet to 877-207-0198.

Patient name: TANAWANDA KOLBAKH
Patient date of birth: **8/21/1946**
Cardholder ID: H84826292
Patient address: 1316 E ASH STREET BLYTHEVILLE, AR 72315
Patient phone number:

1. **Drug name:** PRODIGY AUTOCODE METER KIT
   Drug strength:
   Directions: _____
   Quantity: _____ **Number of refills:** _____
   Fill date: 2/23/2026
2. **Drug name:** ZOCOR 20 MG TABLET
   Drug strength:
   Directions: _____
   Quantity: _____ **Number of refills:** _____
   Fill date: 2/23/2026
3. **Drug name:**
   Drug strength:
   Directions: _____
   Quantity: _____ **Number of refills:** _____
   Fill date: 1/1/0001

Please provide supervising prescriber information (if applicable):
Prescriber name: _____
Prescriber phone number: _____
Prescriber address: _____
DEA number: _____
NPI number: _____
Prescriber signature: _____
Please sign manually; stamped signatures are not allowed.
Date signed: _____
DEA number:
NPI number (required):
Prescriber name: _____
Prescriber phone number: _____
Prescriber address: _____

This form is not valid for controlled substances.

RTM1620929A01.1

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