

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**

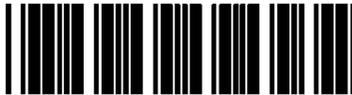
SENDER FAX: **877-207-0198**

NUMBER OF PAGES: Two
(INCLUDING THIS
COVER)

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.



The information transmitted is intended only for the person or entity to whom it is addressed and may contain **confidential** material. If you receive this material/information in error, contact the sender and delete or destroy the material/information. Thank you.



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: _____

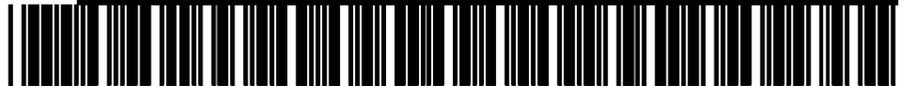
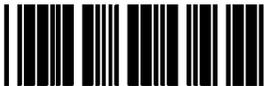
NPI number (required): _____

Prescriber name: _____

Prescriber phone number: _____

Prescriber address: _____

This form is not valid for controlled substances.



RTM1620929A01.1