

PATIENT PRESCRIPTION CORRECTION REQUEST

Instructions:

1. Provide the information requested below and return the signed request.
2. Mail or e-mail the completed application to:

Pennsylvania Prescription Drug Monitoring Program Office

ATTN: Patient Correction Request

625 Forster Street

9th Floor, RM 912

Health and Welfare Building

Harrisburg, PA 17120

Email: RA-DH-PDMP@pa.gov

PATIENT INFORMATION			
First Name:	Middle Name:	Last Name:	Suffix: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> Other _____
Alternative First Name:	Middle Initial:	Maiden Name:	
Gender: <input type="checkbox"/> F <input type="checkbox"/> M		DOB: MM/DD/YYYY	
PHARMACY/DISPENSER INFORMATION			
Pharmacy/Dispenser Name:			
Pharmacy/Dispenser Address:			
City:	State:	ZIP Code:	
PRESCRIPTION INFORMATION			
Name of the Prescriber:			
Prescription Date: MM/DD/YYYY		Prescription Filled/Picked-up: MM/DD/YYYY	
Prescription Number(s):			
Description of the error: <input type="checkbox"/> Incorrect Medication <input type="checkbox"/> Incorrect Quantity <input type="checkbox"/> Incorrect Date <input type="checkbox"/> Incorrect Patient Demographics <input type="checkbox"/> Other			

AGREEMENT

To my knowledge the information provided in this document is accurate. The above describes error or errors identified in the PA PDMP system. I understand that this form with unclear or incomplete descriptions may not be processed. Unsigned forms will not be processed.

All the information entered in the PA PDMP system comes from pharmacies or prescribers who dispense in the Commonwealth of Pennsylvania. I understand that the pharmacy or dispenser needs to correct the information in their system and submit a corrected record to the PDMP system. I understand that the PA Department of Health will not modify any data submitted to the PA PDMP system.

Note: With this completed correction request form, the PDMP office will contact your pharmacy or dispenser on behalf of you to notify them of this error and request that they investigate and submit any necessary correction(s) to the PA PDMP AWARxE system via PMP Clearinghouse.

Signature:

Date:

INTERNAL USE ONLY

Request Number:

Date Approved:

Date Updated to

Date Received:

Pharmacy/Dispenser:

Received by:

Previous requests:

Comments/Notes: