pennsylvania
DEPARTMENT OF HEALTH
PRESCRIPTION DRUG MONITORING PROGRAM

Website: www.doh.pa.gov/pdmp
Phone: 844-377-7367 (844-377-PDMP) from M-F 8am to 4pm EST

PATIENT PRESCRIPTION RECORD CORRECTION REQUEST

Instructions:

1. To begin the correction process, first contact the pharmacy directly to correct an error with your prescription records. If your issue remains unresolved, submit this completed form following the instructions provided.
2. You will need information from your Prescription History Report to accurately complete this form. To obtain a copy of your prescription records submit the Patient Prescription History Request Form (visit www.doh.pa.gov/pdmp and click on "Patients").
3. Provide the patient and prescription information requested below. All fields marked with an asterisk (*) are required.
4. Return the signed request form with a photocopy of a valid government issued photo identification (U.S. driver's license, state identification card, or passport).
5. Mail or e-mail the completed form to:

Pennsylvania Prescription Drug Monitoring Program
ATTN: Patient Record Correction Request
625 Forster Street
Room 604
Health and Welfare Building
Harrisburg, PA 17120
Email: ra-dh-pdmp@pa.gov

PATIENT INFORMATION			
*First Name:	Middle Name:	*Last Name:	Suffix: ○ Sr. ○ Jr. ○ Other:
Alternative First Name:	Middle Initial:	Maiden Name:	
*Gender: ○ Male ○ Female ○ Other/ Prefer not to say	*DOB (MM/DD/YYY):	*Type of identification provided:	

*CURRENT ADDRESS		
*Street:	Apt/Unit:	PO Box:
*City:	*State:	*ZIP Code:
*Telephone #:	*E-Mail:	

PRESCRIPTION INFORMATION		
Note: Providing accurate and complete information will minimize the processing time of your request. Use the information from your Patient Prescription History Report for identifying the prescription numbers in error.		
*Prescription Number(s):	*Date Written (MM/DD/YYYY)	*Date Filled/Picked-Up (MM/DD/YYYY)

*Detailed Description of the error:

◯ Incorrect Medications ◯ Incorrect Quantity ◯ Incorrect Date ◯ Incorrect Patient Information ◯ Other

Additional space is available on the next page. If more space is needed, please print and include another copy of this page.

ADDITIONAL NOTES

AGREEMENT	
By signing below, I certify all information is true and correct to the best of my knowledge. The information I included describes an error or errors identified in the Pennsylvania Prescription Drug Monitoring Program (PDMP) System. I understand that this form may not be processed if it is incomplete or if the descriptions are unclear. I understand that unsigned forms will not be processed. I understand that all information entered in the PA PDMP System comes from pharmacies or prescribers who dispense controlled substance medications in the Commonwealth of Pennsylvania. I understand that the pharmacy or dispenser must correct the information in their pharmacy system and submit a corrected record to the PDMP. I understand that the PA Department of Health will not modify any data submitted to the PA PDMP system. By signing below, I give permission to the PDMP Office to contact pharmacies or dispensers on my behalf to notify them of this error and request that they investigate and submit any necessary corrections to the PA PDMP system.	
*Signature:	*Date:

Print