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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