

Pharmacy Change Order Request Form (Available online at www.in.gov/inspect)

Indiana Scheduled Prescription Electronic Collection & Tracking *Protecting Hoosiers One Prescription At A Time*

Required Field

Pharmacy Change Order Request

Place the errant or invalid DEA number (ex: AB0000000) that requires correcting here. Below you will provide the individual Rx numbers for each of the records that contain the errant DEA number.

Change Order Number: Pharmacist DOB: (mm/dd/yyyy format)

AB0000000	MM/DD/YYYY
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Pharmacy Name: IBH Pharmacy	Pharmacist Name: Joe Smith
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Pharmacy NABP: 1534422	Pharmacist Professional License Number:
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Pharmacy Contact Information

Address Line 1:	Email Address:
<input type="text"/>	<input type="text"/>
Address Line 2:	City:
<input type="text"/>	<input type="text"/>
Address Line 3:	State/Province:
<input type="text"/>	Indiana <input type="text"/>
Telephone Number:	Zip/Postal Code:
<input type="text"/>	<input type="text"/>
Fax Number:	Country/Region:
<input type="text"/>	United States <input type="text"/>

This section must be fully completed for each Change Request.

DISCLAIMER

I (the Dispenser/Practitioner) attest that I am not submitting a change order request under false pretense in an effort to alter or fabricate patient information. I understand that all valid or invalid data modifications are solely my responsibility as the dispenser/practitioner.

I understand that INSPECT is under no obligation to investigate the validity of my Pharmacy Change Order Request and Digital Signature (*Notwithstanding my pharmacy NABP number, professional license number, DEA number, my date of birth and name*). I am duty-bound to abide

by all applicable Federal and State guidelines including, but not limited to, IC-35-48-7 and The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Misuse of INSPECT's data constitutes a criminal offense and may result in the suspension/revocation of access privileges, or, in some cases, action against offending accountholder's and/or agent's professional license.

I acknowledge/agree to the Electronic Signature Agreement

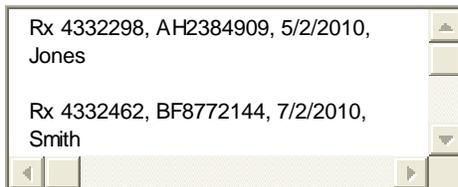
Reason for Change

Changes Requested

The Following Areas Can Be Modified:

PRESCRIBER INFO:

- **DEA Number (If the prescription reported has been attributed to the wrong prescriber)**



Here you should provide the **Rx number** of the errant record along with the **correct DEA number** that the prescription should be attributed too, the **fill date**, and the **patient's last name**. (The fill date, last name, and Rx # are located on the .pdf for that DEA number) The DEA number should always be verified by checking the hard copy prescription itself

DATE INFORMATION:

- **Rx Written (If the written date reported for the prescription is incorrect)**
- **Rx Filled (If the filled date reported for the prescription is incorrect)**



Since date information should be provided in the box above, you may leave this box blank.

PRESCRIPTION SPECIFIC INFO:

- **Rx Number (If the prescription number reported is incorrect)**
- **Refill Code (If the code indicating whether the prescription is new or a refill is incorrect)**
- **Days Supply (If the estimated number of days the prescription will last is incorrect)**

- **Quantity (If the metric units of drug being dispensed is incorrect)**

<input type="text"/>		You may leave this box blank.
PATIENT NAME	PATIENT DOB	If the errant DEA number applies to more than one patient's records, you may leave this section blank.
<input type="text"/>	<input type="text"/>	

Signatures

In order to modify existing records within the prescription management program system, you, or your authorized representative, will be required to use an electronic signature. Please be aware that an electronic signature is as legally binding as a handwritten signature. [Click here to read the full Electronic Signature Agreement](http://www.in.gov/inspect) www.in.gov/inspect

Requested By:

Date:

Modified By: (INSPECT Staff Person) Date:

