Doctors Optimizing Care

Practice Enrollment Form

Please complete this form prior to referring patients to our program.

Practice Name: ____

Mailing Address: ____

Contact Person: ____
Practice staff taking lead on DOC RxR referrals

Phone: ________________________ **Fax:** ________________________

Email: ______________________________

☐ **Please send us information about MSV Membership**

As a practice participating in the Medical Society of Virginia Foundation's DOC RxRelief program, we agree to the following:

- We will send the DOC RxRelief advocate prescription requests and any necessary documents as efficiently as possible.
- We will accept delivery of medications from the pharmaceutical companies, retain the packaging slip for the DOC RxRelief advocate, and keep the prescriptions in a secure area until picked up by the patients.
- We will participate in site visits conducted by the DOC RxRelief advocate as necessary.
- We will immediately notify the DOC RxRelief advocate of any concerns or ideas to improve the program procedures.

In addition, we understand that the DOC RxRelief is an evolving program, and that any feedback we can provide to improve the program will increase its aptitude to assist more patients in securing free-of-charge prescription medications.

Signature: ______________________________ **Date:** ____________

Fax this form and completed MD list form to 804-377-1056 / Attn: Katherine

DOC Rx Relief Doctors Optimizing Care

Physician Listing

Practice/Group Name: ____

Physician Name	MD/DO	VA Lic # & Exp. date	DEA # & Exp. date	Primary office location