United Support Services, Inc.

"The works of many coming together for the good of One"

Prescription Medication Discontinue Form

Member's Name: Member's Medicaid #:

Member's DOB: Member's Record #:

Medications	Dosage	Discontinue Instructions	Discontinue Date

Doctor's Name (Print Name):	Phone Number:
Address:	Fax Number:

This patient and/or patient's guardian has received ☐ written/ ☐ oral information from me (or my assistant) about the discontinuation of these medications and their potential side effects.

Physician's Signature: Date: