



## Over the Counter Medications (FSA Prescription) Patient Instructions and Prescription Form (See Form on Page 2)

Starting on January 1, 2011, the new federal law requires a prescription for some of the over-the-counter (OTC) medicines if you want to get reimbursed through your Flexible Spending Account (FSA). Please refer to the patient fact Sheet for more information on which OTC medications require prescription forms.

- **Date:** Patients should leave this blank. Prescription will be dated when it is signed by the physician.
- 1) **Patient** will fill in the following information on the prescription (please print with a pen):
    - **Patient Name**
    - **Registration Number:** 8 digit number on the UofM blue hospital card.
    - **Date of Birth:** Patient's birthday.
    - **Phone Number:** Telephone number where we can reach you during the day.
    - **Physician:** Put a check mark next to your doctor's name.
    - **Medication Name:** Name of the medicine EXACTLY as it appears on the box.
    - **Strength:** Strength of the medicine can be found on the front of the box. If not, look under the active ingredients section.
    - **Dose:** Dose means how many or how much of the medicine you take or use each time.
    - **Quantity:** Total number or amount of medicine per bottle or container.
    - **Directions:** Number of times you take or use the medicine in a day. PRN means use as needed.
  - 2) Drop off the completed OTC prescription form at your Health Center or mail for physician signature using the address on the form. (see next page)
  - 3) Our staff will contact you when the OTC prescription has been signed by your physician.
  - 4) If you have any questions, please contact us at the phone number listed on the OTC prescription form. (see next page).



## Over the Counter Medications (FSA Prescription)

**Briarwood Center for Women, Children and Young Adults**  
400 East Eisenhower Parkway, Building 2, Suite B  
Ann Arbor MI 48108  
(734) 232-2600

Date: _____	Provider Name: _____
Patient Name: _____	_____
Reg Number: _____	NPI Number: _____
Date of Birth: _____	_____
Phone Number: _____	_____

	Medication Name	Strength	Dose	Quantity	Directions
1					_____ times per day PRN
2					_____ times per day PRN
3					_____ times per day PRN
4					_____ times per day PRN

Refills: PRN

\_\_\_\_\_  
Physician Signature

Total Number of Medications on this Prescription \_\_\_\_\_