Wholesale Supplies

Instructions: Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date.

Order Form			
	Referral source (i.e. physician, website)	Follow-up on order status with	Order Date
	Referral source name	Best day to follow-up	Phone
	Referral relation to patient	Best time to follow-up	Email

Bill to Information		Ship to Information	
Name BLN account-seq #		Name BLN account-seq #	
Bill to address City	Phone / E-mail State Zip County	Ship to address City	Phone / E-mail State Zip County
Purchase Order Number	Terms	Purchase Order Number	Terms

Products			
Quantity	NDC #, catalog # or product description	Price Each Extended Price	HCPCS Code
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Additional Comments

Shipping / Delivery ☐ Expedite

☐ BLN Best Method
☐ UPS ☐ Ground
☐ USPS ☐ Next Day ☐ Second Day
☐ Other ______________________

Ship to address ☐ Same as bill to address

Payment

☐ Check
☐ Mastercard ☐ Visa
☐ American Express ☐ Discover

Name on Credit Card

Credit Card Number

Credt Card Expiration Date

For Office Use Only: Routing

Initial	Routed to	Initial	Requested to
	Order Processing ☐ Pharmacy Date mm / dd / yy		Database Management Date mm / dd / yy
	Documentation Date mm / dd / yy		Management Date mm / dd / yy
	Insurance Verification Date mm / dd / yy		New Client / Group Entry Date mm / dd / yy
	Shipping Date mm / dd / yy		Other Date mm / dd / yy

For Office Use Only: Notes