MIDWEST HEALTH MANAGEMENT SERVICES, LLC
HEALTH PROFESSIONALS ASSISTANCE PROGRAM
4109 S. CARNEGIE CIRCLE SIOUX FALLS, SD 57106
605-275-4711 * Fax 605-275-4715

Please take a few moments to complete this form, and then fax or mail the completed form to MWHMS/HPAP. This form must be completed by the practitioner only. If you have any questions, please contact MWHMS/HPAP.

NAME OF PATIENT: _____
(Please Print)

PRESCRIPTION INFORMATION					
Date of Prescription	Medication	Dose & Frequency	Quantity Prescribed	Reason for Medication	Number of Refills/Prescription End Date

I have been informed that this patient is participating in MWHMS/HPAP.

_____
PRACTITIONER NAME (Please Print)

_____
PRACTITIONER SIGNATURE

_____
DATE

_____
OFFICE TELEPHONE

_____
OFFICE ADDRESS