



VACATION REQUEST FORM

ALL VACATION REQUEST FORMS MUST BE SENT TO THE RX MEMBER EXPERIENCE DEPARTMENT
AT: RXMEMBEREXPERIENCE@HEALTHSUN.COM PHONE: 877-336-2069. FAX: 877-452-7496

FOR CONTROLLED SUBSTANCES CIII - CV PLEASE ATTACH THE PRESCRIPTION(S) TO THIS FORM.

Member's Information

Name:	Date of Birth:	Sex: F M
ID #		
Requestor's Name (CENTER/PCP OFFICE)	Members Phone Number:	
Address:	Apt.#	
City:	State:	Zip Code:

▶ WILL BE AUTHORIZED TWO WEEKS PRIOR TO MEMBERS DEPARTURE DATE ◀

When is member leaving on vacation: _____

Length of vacation (Vacation supplies cannot exceed 90 days) _____

Pharmacy Name/Telephone Number: _____

Prescribing Physician's Information

Dr.			
Address:	City:	State:	Zip:
Phone #	Fax #	Office Contact Name:	

Requestor's Signature: _____

Date: _____

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

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DRUG NAME	QUANTITY AND DAY SUPPLY	DIRECTIONS

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