Uniform New Jersey Prescription Blanks Order Form

Please print clearly to avoid any mistakes

CUSTOMER INFORMATION/BILLING

PRACTICE NAME

STREET ADDRESS (REQUIRED FOR UPS SHIPMENT) CITY, STATE AND ZIP

PHONE NUMBER (INCLUDE AREA CODE) | FAX NUMBER (INCLUDE AREA CODE)

NAME OF PURCHASER | EMAIL ADDRESS

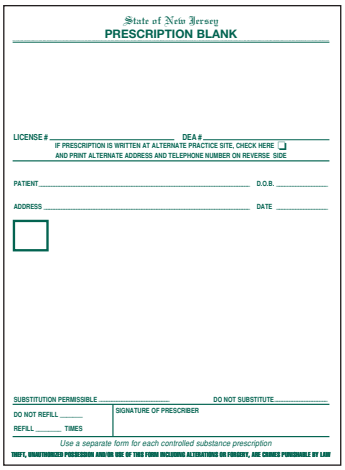
OFFICE CONTACT PERSON | **EMAIL ADDRESS** | **TEL (INCLUDE AREA CODE)**

Ordering Instructions:

1. Per state requirements, all orders and reorders for Uniform New Jersey Prescription Blanks must be submitted in writing via mail, fax, and/or email.
2. Use one Order Form per prescription order. Multiple prescriber names and one address may be printed on the front of each prescription. Additional addresses may be printed on the back for an additional cost.
3. **The address used for shipping must match with the listing of authorized prescribers and health care facilities on file with the licensing board.**
4. License numbers **must be** provided for each prescriber facility.
5. The signature of each authorized prescriber or health care facility representative **must be** provided with each order.
6. **Payment via credit card only. Completed credit card form with signature must accompany this order or it will not be processed.**

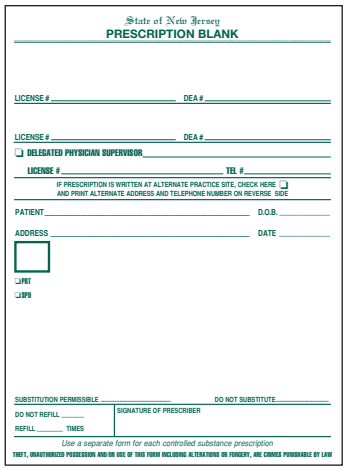
ORDERING INFORMATION: Please Check One

Healthcare



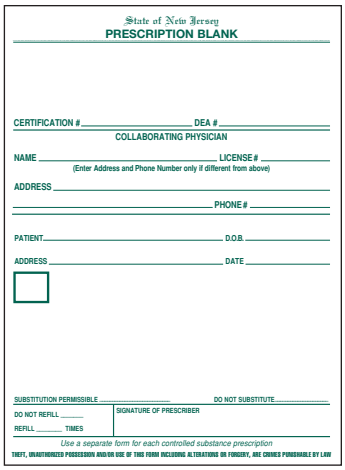
MD, DO, DDS, DMD, DPM, DVM, VMD, MVSc

- ❑ 445821 1-Part
- ❑ 445821B 1-Part, Alternate Address
- ❑ 445821-2 2-Part
- ❑ 445821B-2 2-Part, Alternate Address



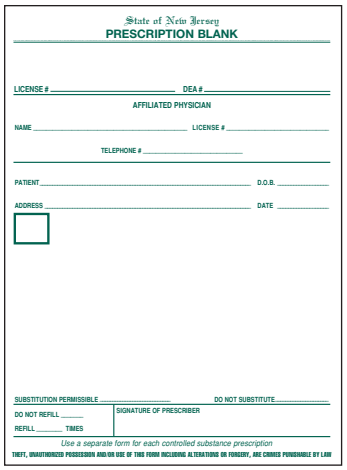
Physician Assistant

- ❑ 7823 1-Part
- ❑ 7823B 1-Part, Alternate Address
- ❑ 7820 2-Part
- ❑ 7820B 2-Part, Alternate Address



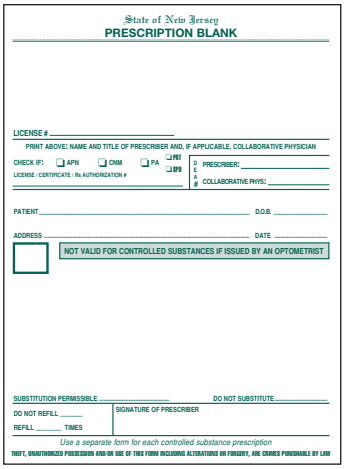
Advanced Practice Nurse

- ❑ 445801 1-Part
- ❑ 445801B 1-Part, Alternate Address
- ❑ 445801-2 2-Part
- ❑ 445801B-2 2-Part, Alternate Address



Certified Nurse Midwife

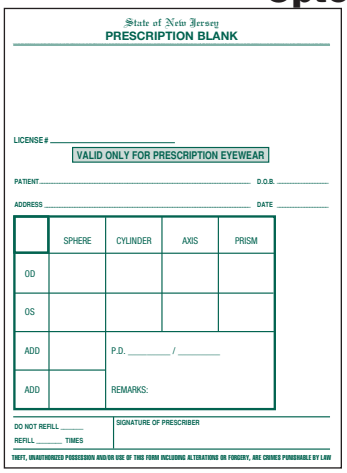
- ❑ 445811 1-Part
- ❑ 445811B 1-Part, Alternate Address
- ❑ 445811-2 2-Part
- ❑ 445811B-2 2-Part, Alternate Address



Health Care Facility

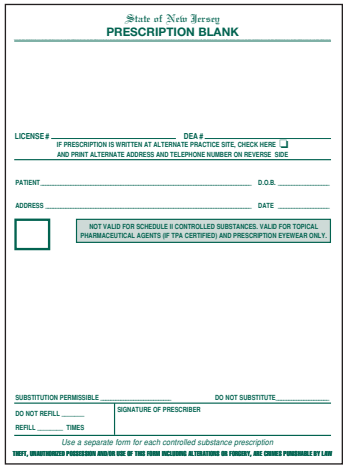
- ❑ 445831 1-Part
- ❑ 445831B 1-Part, Alternate Address
- ❑ 445831-2 2-Part
- ❑ 445831B-2 2-Part, Alternate Address

Optometrist



For Exclusive Use When Prescribing Eyewear

- ❑ 445861 1-Part
- ❑ 445861B 1-Part, Alternate Address
- ❑ 445861-2 2-Part
- ❑ 445861B-2 2-Part, Alternate Address



Optometrists (without eyewear box)

- ❑ 445841 1-Part
- ❑ 445841B 1-Part, Alternate Address
- ❑ 445841-2 2-Part
- ❑ 445841B-2 2-Part, Alternate Address
- ❑ **Check for contact lens warning**

CUSTOM IMPRINT OR INSTRUCTIONS

FORM TYPE: Please Check One (Prices subject to change without notice)

1-Part Pads – Single Sided *(100 blanks per pad)*

❑ 5 pads	❑ 10 pads	❑ 20 pads	❑ 40 pads	❑ 50 pads	❑ 80 pads	❑ 100 pads
$80.00	$93.00	$128.00	$199.00	$235.00	$358.00	$423.00

1-Part Pads with Alternate Address – 2 Sided *(100 blanks per pad)*

❑ 5 pads	❑ 10 pads	❑ 20 pads	❑ 40 pads	❑ 50 pads	❑ 80 pads	❑ 100 pads
$115.00	$135.00	$195.00	$283.00	$330.00	$477.00	$567.00

2-Part Carbonless Pads *(50 blanks per pad)*

❑ 10 pads	❑ 20 pads	❑ 40 pads	❑ 80 pads	❑ 100 pads	❑ 160 pads	❑ 200 pads
$135.00	$189.00	$260.00	$419.00	$499.00	$680.00	$800.00

2-Part Carbonless Pads with Alternate Address – 2 Sided *(50 blanks per pad)*

❑ 10 pads	❑ 20 pads	❑ 40 pads	❑ 80 pads	❑ 100 pads	❑ 160 pads	❑ 200 pads
$189.00	$274.00	$367.00	$590.00	$698.00	$952.00	$1120.00

1 Sided Laser Forms on 8.5 x 11 Sheets ❑ *TOP LEFT POSITION* ❑ *CENTER POSITION*

❑ 250 Sheets	❑ 500 Sheets	❑ 1000 Sheets	❑ 2000 Sheets	❑ 4000 Sheets	❑ 5000 Sheets
$108.00	$155.00	$269.00	$369.00	$599.00	$685.00

SHIPPING COSTS

costs are in addition to printing charges – call for pricing

❑ **Same Day Proof Add $25.00**	❑ **Same Day Proof-Printing & Shipping Add 50% To Printing Costs**	❑ **Custom Imprinting Prescription Specific Information or Warnings Add $35.00**

Information to be printed on Prescription Blank:

1. Practice or Facility Name (if to be printed): _____
2. Prescriber Name: _____ Degree: _____
3. Practice or Specialty (only if to be printed on pads below prescriber name[s]): _____ License # _____

   Address to be printed on front: _____

   _____ National Provider Identifier # (NPI #): _____

   Telephone # to be printed: _____ Fax # (if to be printed): _____
4. Specify if Applicable: Dea # _____ TPA Cert # _____
   (if DEA # is not provided, a blank line will be printed to be filled in by prescriber where applicable.) (For Opto, must be printed.)

   Facility Provider # _____ Certification # _____

MUST HAVE EACH TIME ORDER IS PLACED

Prescriber Signature: _____

IMPORTANT: If more than one prescriber is listed on the same blank, one of the prescribers is to be responsible for the shipment. That person must sign below:

_____

PLEASE NOTE: *By signing, you are the responsible party for this shipment of prescription blanks. Please make certain that the ship to address given below is the same as it appears with your medical licensing board.*

OPTIONAL: Additional doctors to be printed on the same prescription blank (or one collaborating physician if ordering pads for Nurse Practioner/Certified Nurse Midwife/Physician Assistant):

1. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA #: _____ NPI #: _____

   ***Prescriber Signature:** _____

2. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA #: _____ NPI #: _____

   ***Prescriber Signature:** _____

3. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA #: _____ NPI #: _____

   ***Prescriber Signature:** _____

4. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA #: _____ NPI #: _____

   ***Prescriber Signature:** _____

5. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA #: _____ NPI #: _____

   ***Prescriber Signature:** _____

6. Prescriber Name: _____

   License #: _____ Degree: _____

   DEA #: _____ NPI #: _____

   ***Prescriber Signature:** _____

OPTIONAL: Additional addresses to be printed on the back of prescripion blanks (must include phone number):
If additional addresses are required, attach separate sheet (up to 4 addresses).

Street: _____

City, State, Zip: _____

Phone: ( ) _____

Street: _____

City, State, Zip: _____

Phone: ( ) _____

Ridgewood PRESS .com

Phone: 201.670.9797
Fax: 201.670.9798

This credit agreement must be completed and returned with your order forms in order to process your order

CREDIT CARD CHARGE AUTHORIZATION AGREEMENT

I, _____, the holder of (check one, please):

VISA ☐ MasterCard ☐ American Express ☐ Discover ☐

Card Number: _____, Expiration Date: _____/_____

3 digit code that is on the back of your Visa, MasterCard, Discover, or 4 digit code on the front of your American Express Card_____.

I hereby authorize R. Press, Inc., as the parent company of Ridgewood Press.com, to charge my credit card for any invoice related to this order. With any RX Pad order a Non-Refundable $50.00 deposit will be charged to this credit card when the order is placed and the 1st proof has been sent via email or fax. I agree not to chargeback Ridgewood Press.com once this proof has been sent. This $50.00 deposit will go towards the total cost of my order. Once the proof is approved, R. Press, Inc. will process and ship the RX Pad order via UPS to the doctor's registered NJ State license address (required by law) **and a signature is required at time of delivery.** I also authorize Ridgewood Press.com to charge the above card for these shipping charges. I have read this agreement and understand that I will be held fully responsible for its terms and charges and agree not to chargeback Ridgewood Press.com if order is cancelled.

Cardholder:_____

Signature:_____

Company:_____

Mailing Address of Card:_____

City, State, Zip of Card:_____

Telephone: (_____) _____

Date: _____ /_____ /_____

Please scan this completed form and email to: rx@ridgewoodpress.com
Or
Fax this form to our RX Dept: 201.670.9798