Medication Refill Request

Date: [Insert Date]

To: [Pharmacy Name]

From: [Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

Email: [Your Email Address]

Patient ID: [Your Patient ID]

Rx Number: [Prescription Number]

Dear [Pharmacist's Name or Pharmacy Staff],

I hope this message finds you well. I am writing to request a refill for my prescription for [Medication Name], which I use as a sleep aid. My prescription is due to run out on [Insert Due Date], and I would like to ensure I have enough medication to continue my treatment.

Please let me know if you need any further information or if there are any issues with processing this refill request.

Thank you for your assistance.

Sincerely,

[Your Name]