Patient Insurance Coverage : PLEASE SEND COPY OF FRONT AND BACK OF INSURANCE CARD

Patient is covered by: □ Medicaid FFS □ Medicare □ Private/Commercial Insurance □ Other
If "other", please specify: _____
Name as it appears on card: _____

Primary Insurer: _____
Insurance I.D. _____
Insurance Bin #: _____
Insurance PCN #: _____
Patient Group #: _____

Secondary Insurer: _____
Insurance I.D. _____
Insurance Bin #: _____
Insurance PCN #: _____
Patient Group #: _____

Patient Pharmacy Information:

Primary Pharmacy: _____
Phone: _____ Fax: _____

Delivery Information:

Deliver to: □Home □Doctor □CURATIVE office
Delivery requirements: _____

Fed Ex: ☐ Checking this box authorizes receipt of medication in mail waiving need for signature

Blister Pack or any other packaging requirements: _____
Any Callback precautions: _____
Any other information: (ex. No Safety Caps) _____

Please check all that apply:

___ Automatically refill my prescriptions before I run out of medicine
___ I am interested in having Pharmacy fill all of my medication needs

I hereby authorize Pharmacy to oversee and dispense my prescription medications

Name: _____ Date: _____

PATIENT OR GUARDIAN MUST SIGN TO ATTEST THAT INFORMATION ON THIS FORM IS CORRECT:

PATIENT SIGNATURE: _____ **TODAY'S DATE:** _____/_____/_____

PRACTICE SIGNATURE: _____ **TODAY'S DATE:** _____/_____/_____

REMEMBER TO SEND COPY OF ALL PATIENT INSURANCE CARDS AND SCRIPTS WITH ENROLLMENT FORMS