CompreCare | Rx

Specialty Pharmacy
JCAHO Accredited

MISC ENROLLMENT FORM

Phone: 800-541-2030
Fax: 888-862-4769

PATIENT INFORMATION		
Patient Name	Male ☐ Female ☐	Allergies NKDA
Date of Birth	SSN#	Weight Kg Lb Date
Address	City	State/Zip
Phone # (Home)	Work #	Email Address
Caregiver	Case Manager	

INSURANCE INFORMATION		
Primary Insurance		Policy Holder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

DIAGNOSIS/MEDICAL INFORMATION (PLEASE SPECIFY PRIMARY & SECONDARY DIAGNOSIS)
☐ CD-10
☐ Other ICD-10
Additional Medical Information
Is patient new to therapy? ☐ Yes ☐ No Date of diagnosis / /

PREVIOUS MEDICATIONS (PLEASE SPECIFY DOSAGE & TIMES ON THERAPY)		
Medication Strength & Dose	Dates & Therapy	Reason for Discontinuing

PRESCRIPTION INFORMATION				
Medication	Dose	Direction	Quantity	Refills

DELIVERY INSTRUCTIONS	
☐ Physician's Office ☐ Patient's Home ☐ Other	
Address	Phone #
City/State/Zip	Date Medication Needed / /

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION			
Physician Name		Phone	Fax
Address		City/State/Zip	
NPI #	DEA #	Office Contact	

Physician Signature Date
(signature required to process prescription)