Specialty Pharmacy Services Enrollment Form

Please complete the form and fax to: **402.861.4941**

1. PATIENT INFORMATION (Please print or type clearly)

Name ________________________________ Today's Date ______________

Street Address ____

City ____________________ State _________ Zip Code ______________

Phone Numbers (Please Include Area Code): Day __________________________

Night ______________________ Cell Phone ______________________

Date of Birth ____________ Height ______ Weight _______ ❑ Male ❑ Female

Primary Caregiver ________________________ Phone # ______________

Emergency Contact ________________________ Phone # ______________

INSURANCE INFORMATION:

Primary Insurance ___________________________ Phone # ____________

Name of Cardholder ____

SSN # _________________ ID # _____________ Group # ____________

Secondary Insurance _________________________ Phone # ____________

Name of Cardholder ____

SSN # _________________ ID # _____________ Group # ____________

DELIVERY INSTRUCTIONS:

❑ Home ❑ Physician ❑ Office ❑ Work ❑ Other ______________________

Street Address ____

City ____________________ State _________ Zip Code ______________

2. PRESCRIBER INFORMATION

Physician Name ____

DEA # _______________ NPI # ______________ UPIN ____________

Facility Name ____

Street Address ____

City _______________________ State _________ Zip Code ______________

Phone # ___________________________ Fax # ________________________

Form Submitted By ____

PRIMARY DIAGNOSIS: (Please provide ICD-9 Code plus Description)

____

PRESCRIPTION INFORMATION:

Date needed ____________________ Permission to contact patient? ❑ Yes ❑ No

Medications Needed	*Sig*	*# of Refills*

Physician Signature ____

CONTACT:

Healthcare Professional ______________________ Phone # ______________

3. FAX COMPLETED FORM to 402.861.4941

Please include copies of the patient's medical and prescription insurance cards – the front and back.

877.Rx-HYVEE (877.794.9833) ■ Fax 402.861.4941 ■ 10004 S. 152nd Street, Suite C, Omaha, NE 68138