Homescripts >>>> Homescripts An envolve Solution

Pharmacy TRUST PROFESSIONALS

MEMBER ENROLLMENT FORM

STEP 1 – PERSONAL INFORMATION

NAME:_____ DATE OF BIRTH (mm/dd/yy):_____

ADDRESS:_____ CITY:_____ STATE:_____

ZIP CODE:_____ HOME PHONE:_____ MOBILE PHONE:_____

ALT CONTACT:_____ PHONE:_____ RELATIONSHIP TO MEMBER:_____

Allergies: ❑ None ❑ Aspirin ❑ Codeine ❑ Iodine ❑ Penicillin ❑ Sulfa ❑ Other: _____

Health Condition(s): ❑ Thyroid ❑ Diabetes ❑ Glaucoma ❑ Heart Conditions ❑ High Blood Pressure ❑ Other: _____

STEP 2 – HEALTHCARE PRACTITIONER INFORMATION

NAME (PRINTED):_____ PHONE#:_____

OFFICE LOCATION:_____

STEP 3a – PRESCRIPTION INSURANCE INFORMATION

POLICYHOLDER (if different than above):_____ RELATIONSHIP TO MEMBER: _____

CARDHOLDER ID #_____ RX GROUP #: __

RX BIN #:_____ PCN/PLAN CODE #: _____

INSURANCE NAME:_____ INSURANCE PHONE #: _____

STEP 3b – SECONDARY PRESCRIPTION INSURANCE *(if applicable)*

POLICYHOLDER (if different than above):_____ RELATIONSHIP TO MEMBER:_____

CARDHOLDER ID #_____ RX GROUP #: __

RX BIN #:_____ PCN/PLAN CODE #: _____

INSURANCE NAME:_____ INSURANCE PHONE #: _____

STEP 4 – PAYMENT INFORMATION

CREDIT CARD TYPE: ❑ MC ❑ VISA ❑ DISCOVER USE THIS CARD FOR FUTURE ORDERS? ❑ YES ❑ NO

CREDIT CARD #:_____ EXP DATE:_____/_____ CVV2 CODE:_____

If someone besides the member is responsible for paying the prescription costs, please provide their information below:

Name:_____ Phone:_____ Relationship to Member:_____

CARDHOLDER SIGNATURE: _____

(Turn over to complete)

Toll-free: 1-888-239-7690

TTY: Please dial 711 for phone relay assistance

Customer Service Hours: M – F 9am – 6pm EST, Sat 10am – 2pm EST

STEP 5 – MEDICATION TRANSFER INFORMATION *(optional)*

Complete this step if you would like us to transfer medications from your current pharmacy to Homescripts.

Rx #	Medication Name	Pharmacy Name	Pharmacy Phone #

1

SEND RXS BY MAIL TO:

HOMESCRIPTS PHARMACY
Attn: New Member Enrollment
500 Kirts Blvd.
Troy, MI 48084

OR

2

Ask Your Provider to
SEND YOUR PRESCRIPTIONS TO:
HOMESCRIPTS PHARMACY
Attn: New Member Enrollment
500 Kirts Blvd.
Troy, MI 48084
Phone: (888) 239-7690 / TTY: Please dial 711
OR Fax to: (877) 396-5970

STEP 7 – SPECIAL INSTRUCTIONS

Please include any special instructions regarding your order:

_____

_____

I certify that the information provided on this form is correct and authorize the release of all information to Homescripts, I authorize my provider to send my prescription(s) to Homescripts, I authorize my provider to consult with a Homescripts pharmacist regarding any medication related concerns, and I AUTHORIZE HOMESCRIPTS PHARMACY TO SUBSTITUTE ANY FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PROVIDER'S ORDERS AND MY BENEFIT PLAN.

PRINTED NAME: _____

SIGNATURE OF MEMBER OR LEGAL REPRESENTATIVE: _____ **DATE:** _____

❑ Yes, I would like to receive easy-open, non-safety caps.
_____ *Initials*

Please e-mail the completed, saved form to **customerservice@homescripts.com OR** fax to: (877) 396-5970.