MedicoRx Specialty
& HOME INFUSION PHARMACY

Medication Therapy Management Program

Enrollment Form

Toll Free Phone 855-265-7850 Fax 855-450-6717

1 Insurance Policy Holder Information

Name:_____ Insurance Member ID:_____

Street Address:_____ Insurance Group Code:_____

Street Address:_____ Rx BIN#:_____

City, State, Zip:_____ PCN#:_____

Daytime phone ☐☐☐ ☐☐☐ ☐☐☐☐ Referral Group Code:_____

How did you hear about us?_____

Evening phone ☐☐☐ ☐☐☐ ☐☐☐☐ _____

☐ Please send me email notices about the status of the enclosed prescription(s) and online ordering.

_____@_____

MedicoRx will keep this address on file for all orders from this membership until another shipping address is provided by anyone in this membership.

2 Fill out a separate section for each person requesting filled prescriptions. If she/he has prescriptions from more than one doctor, complete a new section for each doctor.

First name ☐☐☐☐☐☐☐☐ Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birthdate (MM/DD/YYY) ☐☐ ☐☐ ☐☐☐☐ Sex ☐ M ☐ F Patient's relationship to Rx insurance holder ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

Doctor's last name ☐☐☐☐☐☐☐☐☐☐ 1st initial ☐ Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name ☐☐☐☐☐☐☐☐ Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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