HealthStat Rx Pharmacy Care Program
Patient Enrollment Form

FAX: 866-437-8411 **PHONE: 866-437-8040**

PATIENT INFORMATION

Name: _____

Street: _____

City, State, Zip: _____

Phone: _____

DOB: _____Allergies:_____

INSURANCE INFORMATION

Insurance Company Name: _____

Member ID#: _____ RX Bin#: _____

Group #: _____ PCN#: _____

Insurance Phone #: _____

DOCTOR INFORMATION

Physician Name: _____ Phone #: _____

Address: _____ City/St/Zip: _____

DEA #: _____ NPI#: _____

PRESCRIPTION INFORMATION (Can be sent electronically)

MEDICATION	STRENGTH	DIRECTIONS	QTY	# of Refills

Patient needs medications delivered by: _____

_____ _____

Dr. Signature Date