



Patient Enrollment Form
Phone: 888.773.7376
Fax: 866.239.5502

UPMC
HEALTH PLAN

Last Name		First Name		Today's Date		Date Needed	
Home Phone Number ()		Work Phone Number ()		Prescriber			
Home Address		City	State	Zip	Address		City State Zip
Shipping Address (if different from home address)		<input type="checkbox"/> Physician	<input type="checkbox"/> Home	Phone Number ()		Fax Number ()	
Social Security Number		Date of Birth		Office Contact			
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		Preference:		<input type="checkbox"/> Fax	<input type="checkbox"/> Phone	<input type="checkbox"/> E-mail	
				E-mail			

INSURANCE INFORMATION (Fill out entirely or fax a copy of patient's insurance card, both sides.)
Primary Insurance: <u>UPMC</u> Insured: _____ Policy #: _____ Group #: _____ Phone #: _____ Rx Drug Card #: _____ Secondary Insurance: _____ Insured: _____ Policy #: _____ Group #: _____ Phone #: _____ Rx Drug Card #: _____
Statement of Medical Necessity
Primary Diagnosis: _____ ICD9 Code: _____

TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:
Medication: _____ Sig: _____ Qty: _____ Dose(s) Refills x _____ Month(s)
<p>CuraScript Pharmacy ensures that every patient is just that – a patient, not a number.</p> <p>We give physicians, patients, and caregivers access to:</p> <ul style="list-style-type: none"> • EXPERIENCED pharmacists and nurses who understand the scope of each disease state they treat • CARING and compassionate social services professionals to provide support and guidance • EXPERT reimbursement personnel to assist patients through the "maze" of insurance coverage • RELIABLE, timely, and convenient delivery to meet everyone's needs

Physicians Signature: _____ UPIN/DEA #: _____ State License#: _____

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS