

FALK PHARMACY

A UPMC Health System Pharmacy

PATIENT ENROLLMENT FORM

Phone: (412) 648-2312

FAX: 412-383-7088

PLEASE CHOOSE WHERE DRUG SHOULD BE
MAILED FOR THIS PATIENT To be sent to Physician's Office or Clinic To be sent to Patient's home**Patient Information**

Patient Name:	Sex: <input type="checkbox"/> M or <input type="checkbox"/> F	SSN:	DOB:
Address:	Insurance Company: UPMC		
City/St/Zip:	Patient ID Number:		
Patient Allergies:	Insurance Phone #:		
Phone (day):	Secondary Insurance (If Any):		
Phone (evening):	Patient ID Number:		
Date Needed By:	(Please send copy of insurance card(s) if available)		

Primary Diagnosis:**ICD-9 Code:****Rx**

Patient Name _____ Date _____

Sig.:

Refill _____

Physician Signature _____
May Substitute _____ May Not Substitute _____**Physician Information**

Physician's Name:	Office Contact:
Hospital/Clinic:	Phone #:
Address:	Fax #:
City/St/Zip:	License #: _____ DEA #: _____

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Please Fax To 412-383-7088

Please fill out and enclose Prior Authorization Form
Available for download at <http://www.upmchealthplan.com/forms.htm>