# Falk Pharmacy

*A UPMC Health System Pharmacy*

**Phone: 412-605-3900**
**Fax: 412-235-1338**

# Patient Enrollment Form

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: ☐ M ☐ 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 avaliable) | | |

Primary Diagnosis:

ICD-9 Code:

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**Rx**

**Patient Name:**______________________________ **Date:**________________

**Sig.:**

**Refill:** ________________

**Physician Signature:** ______________________________

**Physician Name:**______________________________

In order for a brand name product to be dispensed, the prescriber MUST handwrite "Brand Medically Necessary" on the line below.

______________________________

| Physician's Name: | Office Contact: |
|---|---|
| Hospital/Clinic: | Phone #: |
| Address: | Fax #: |
| City/St./ZIP: | License #: DEA# |

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**Please Fax To 412-235-1338**

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

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