

Enrollment Form



phone: 1.877.829.3137
 fax: 1.417.869.0277

patient information

patient: _____ male
last name, first name female DOB: _____ SS#: _____

address: _____
street city state zip

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ weight: _____ lbs
 kg date: _____

Diagnosis/ICD 9: _____

clinical information

*Complete this section ONLY if you would like Thrifty White Pharmacy to initiate a prior authorization or appeal on your behalf:

prior therapy	reason for discontinuation of therapy	year of discontinuation
	Disease Progression Finished Therapy Toxicity (please specify) _____	

prescription

Medication Form/ Strength/ Dose/ Directions/ Frequency/ Quantity/ Refills

prescriber + shipping information

prescriber (print): _____ office contact: _____

ship to: patient office alternate
shipping address: street city state zip

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Dan's Discount Drug Mart and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

insurance information: please fax copy of insurance card (front + back)

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information

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