Enrollment Form

phone: 1.877.829.3137
fax: 1.417.869.0277

patient information

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

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)