Enroll in Mail-Meds

Fax to Mail-Meds Clinical Pharmacy at (855) 523-0910.
Patient enrollment department (800) 939-2022.
www.mailmeds.com

First Name: _____ Last Name: _____

Address: _____ Apt. No. _____

City: _____ State: _____ Zip Code: _____

Phone (Day): _____ Phone (Evening): _____

Date of Birth (MM-DD-YY): _____ Prescription Plan Name: _____

Bin #: _____ PCN #: _____

Group #: _____ Member I.D.: _____

Social Security: _____ Sex: _____Male _____Female

Known Drug Allergies (List All): _____

Prescription Number	Pharmacy Phone #	Date Last Filled (MM-DD-YY)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Products/Services Needed:

_____ Med-Box™
_____ Med-Pal
_____ Med Reminder PC200
_____ ALRT 500 Remote Monitoring System
_____ Biojector® 2000
_____ Home Training Visit

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Complete this section if you are enrolling someone other than yourself

First Name: _____ Last Name: _____ Title: _____

Organization Name: _____ Phone: _____

Email Address: _____

Special Instructions: _____