Mail-Meds Clinical Pharmacy Enrollment Form

Mail-Meds CLINICAL PHARMACY

2692 Oak Ridge Court
Fort Myers, FL 33901
www.mailmeds.com

Phone: 800-939-2022
Fax: 855-523-0910

NCPDP: 1099919 NPI: 1558369140

Days Supply Left:_____ ICD 10: _____ Date:_____

☐ Vials ☐ MedBox™ (Dosing Intervals)

Referred By:_____

Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Social Security #: _____ Allergies _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ 2nd Phone: _____

Emergency Contact: _____ Phone: _____

Delivery Address: ☐ Same as home address ☐ Other: _____

_____

Phone:_____

Insurance Information

Private Insurance Name: _____

Member ID #: _____

RX Bin #: _____

Medicaid #: _____

Group #: _____

Medicare D#: _____

PCN #: _____

Insurance Phone: _____

Physician Information

Name: _____ Phone: _____

Name: _____ Phone: _____

Date:_____

Prescription Information

_____ # of prescriptions attached _____ # of Transfer prescriptions

Pharmacy Name: _____ Phone: _____

Dose Time	Medication/Strength/Quantity	Prescription No.	Last Filled	Need By	Prescriber

I authorize Mail-Meds to fill my prescriptions and/or transfer my prescriptions from the pharmacy(s) listed above.

Patient Signature: _____ Date: _____