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Member Enrollment Form

STEP 1 - PERSONAL INFORMATION

Name: _____ Date of Birth (mm/dd/yy): _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Mobile Phone: _____

Alt Contact: _____ Phone: _____ Relationship to Member: _____

Allergies: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa Other: _____

Health Condition(s): ☐ Thyroid ☐ Diabetes ☐ Glaucoma ☐ Heart Conditions ☐ High Blood Pressure

Other: _____

STEP 2 - HEALTHCARE PRACTITIONER INFORMATION

Name (Printed): _____ Phone Number: _____

Office Location: _____

STEP 3a - PRESCRIPTION INSURANCE INFORMATION

Policyholder (if different than above): _____ Relationship to Member: _____

Cardholder ID #: _____ Rx Group: #: _____

Rx BIN #: _____ PCN/Plan Code: #: _____

Insurance Name: _____ Insurance Phone Number: _____

STEP 3b - SECONDARY PRESCRIPTION INSURANCE (if applicable)

Policyholder (if different than above): _____ Relationship to Member: _____

Cardholder ID #: _____ Rx Group: #: _____

Rx BIN #: _____ PCN/Plan Code: #: _____

Insurance Name: _____ Insurance Phone Number: _____

STEP 4 - PAYMENT INFORMATION

Credit Care Type: ☐ Visa ☐ Mastercard ☐ Discover Use this card for future orders? ☐ Yes ☐ No

Credit Card Number: _____ Expiration Date: ____/____ CVV Code: _____

If someone besides the member is responsible for paying the prescription costs, please provide their information below:

Name: _____ Phone: _____ Relationship to Member: _____

Cardholder Signature: _____

(turn over to complete)

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STEP 5 - MEDICATION TRANSFER INFORMATION (optional)

Complete this step if you would like us to transfer medications from your current pharmacy to Homescripts.

Rx #	Medication Name	Pharmacy Name	Pharmacy Phone #

STEP 6 - NEW PRESCRIPTION(S) INFORMATION

1

Send Prescriptions By Mail To:

Homescripts Pharmacy
Attn: New Member Enrollment
500 Kirst Blvd., Suite 300
Troy, MI 48084

OR

2

Ask Your Provider to Send Your Prescriptions To:

Homescripts Pharmacy
Attn: New Member Enrollment
500 Kirst Blvd., Suite 300 | Troy, MI 48084
Phone: (888) 239-7690 | TTY: Please dial 711 **OR**
Fax to: (877) 396-5970

STEP 7 - SPECIAL INSTRUCTIONS

Please include any special instructions regarding your order:

_____

_____

STEP 8 - PLEASE READ, SIGN & DATE

I certify that the information provided on this form is correct and authorize the release of all information to Homescripts, I authorize my provider to send my prescription(s) to Homescripts, I authorize my provider to consult with a Homescripts pharmacist regarding any medication related concerns, and I AUTHORIZE HOMESCRIPTS PHARMACY TO SUBSTITUTE ANY FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PROVIDER'S ORDERS AND MY BENEFIT PLAN.

Printed Name: _____

Signature of Member of Legal Representative: _____ Date: _____

☐ Yes, I would like to receive easy-open, non-safety caps. Initials _____

Please email the completed, saved form to customerservice@homescripts.com OR fax to (877) 396-5970