# Pharmacy General Enrollment and Prescription Form

**P: 1-844-443-6879 F: 1-844-329-2447**

ePrescribe to our pharmacy at “GENTRY HEALTH SERVICES” in Avon Lake, Ohio.

## PATIENT INFORMATION

Patient Name ____________________
DOB ___/___/______ SSN ______________ Gender______
Weight ________ Height ________ Phone ______________
Address ____________________
City, State, Zip ____________________
Cell Phone ______________ E-Mail ______________
PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name ____________________
Insurance Co. Phone ______________ Group# ________
Policy Holder Name ____________________
Policy Holder Employer ____________________
Relationship to Patient ____________________
ID# ______________ RxBIN __________ PCN__________

## PRESCRIBER INFORMATION

Prescriber's Name ____________________
Practice Name ____________________
DEA ______________ NPI ______________
Address ____________________
City, State, Zip ____________________
Phone ______________ Fax ______________
Office Contact Person ____________________
Office Contact EMAIL ____________________
Prescription Date ______________ Date Needed __________

**With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.**

**Prescriber Signature** ____________________

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Discount Drug Mart

## Prescription Insurance Information *(please provide copy of patient's insurance card with enrollment form)*

Primary Insurance Name____________________
Primary Insurance Phone ______________ Group# ________
Policy Holder Name ____________________
Policy Holder Employer ____________________
Relationship to Patient ____________________
ID# ______________ RxBIN __________ PCN__________

Secondary Insurance Name____________________
Secondary Insurance Phone ______________ Group# ________
Policy Holder Name ____________________
Policy Holder Employer ____________________
Relationship to Patient ____________________
ID# ______________ RxBIN __________ PCN__________

## Medical Information

Description of Diagnosis ____________________
Date of Diagnosis ______________ ICD-9 Code __________ ICD-10 (must include after 10/1/2014) __________
Therapy Type: ☐ New Start ☐ Restart ☐ Refill Authorization
Latex Allergy: ☐ YES ☐ NO Medication Allergies (please list): ____________________
Other Disease States or Comorbities ____________________
Other Medications Prescribed ____________________
Additional Comments ____________________

## Prescription Information (if brand name is necessary, prescriber must handwrite DAW)

| Medication Name and Dosage Form | Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.