CORAMRx specialty pharmacy services

MedImpact Delivering · Flexible · Choice

Enrollment Form

Fax 866-946-0657 Phone 877-426-7267

Date Needed By:

Patient Information

Patient Name:			☐ Male ☐ Female
DOB:	☐ Allergies:		
Address:		City:	State: / Zip:
Phone # (Home)	(Work)	(Cell)	Email:
Case Manager and Phone:		Emergency Contact and Phone:	

Insurance Information *Please attach copies of cards (front & back)*

Primary Insurance:	Company:	Policy Holder:	
Group #:	Policy #:	Phone #:	Fax #:
Secondary Insurance:	Company:	Policy Holder:	
Group #:	Policy #:	Phone #:	Fax #:

Diagnosis Information *(Please specify primary and secondary diagnoses)*

Primary ICD-9:	Secondary ICD-9:
Is patient new to therapy? ☐ yes ☐ no Date of diagnosis:	
Height:	Weight:

Medication Profile

Medication Strength & Dose

Prescription Information

Medication	Dose/Frequency / Route	Quantity	Refills

Please list ancillary supplies if needed:

Delivery Instructions

Deliver to:	**Ship-to Address:**
☐ Physician's Office	Address:
	City/State/Zip:

Physician Contact Information & Authorization

Physician Name:		Office Contact:	
Phone		Fax:	
Address:		City/State/Zip:	
License #:	DEA #:	UPIN #: ***Required***	NPI #:

Physician's Signature *(required to process prescription)*

_____	_____	_____
may substitute	*may not substitute*	*Date*