



# Broomfield Campus Associate Health Center Pharmacy Enrollment/Change Form

Enroll a new patient.     Update information for an existing patient.

### 1. Submit this form by:

**Mail:** SCL Health Pharmacy Services,  
Good Samaritan Medical Center  
200 Exempla Circle, Lafayette, CO 80026  
**Fax:** 303-689-6126  
**Email:** goodsamrx@sclhs.net (Add "[secure]" to the subject line)

### 2. Submit your prescription by:

Asking your prescriber to e-prescribe to us, fax (number above), or call (303-689-6121 or 855-235-4301).  
Or personally submitting printed prescriptions only by mail or in person (address above). *By law we cannot accept prescriptions you fax or email yourself.*

**Questions?** Pharmacy: **303-689-6121** or Associate Health Center: **303-813-5590** | *Please destroy this form after submitting it to the pharmacy.*

\* Required fields are indicated with a red asterisk below.

PATIENT INFORMATION			
* Last Name:		* First Name:	
* Birthday:	* Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Please no child-proof caps	
* Home Phone #:	* Work Phone #:	* Cell Phone #:	
* Email:			

PRESCRIPTION DELIVERY — * Check One or Both:	
<input type="checkbox"/> New Prescription(s) — I understand my prescription(s) will be delivered to the Associate Health Center.	<input type="checkbox"/> Maintenance Medication(s) — I want my ongoing delivery of maintenance medication(s) delivered to the Associate Health Center instead of my home address (SCL Health associates only)

INSURANCE INFORMATION		
* Insurance Provider:		
* Identification Number:	* If Cigna, Which Plan Type (check one): <input type="checkbox"/> CDHP <input type="checkbox"/> PPO	
* Last Name:	* First Name:	* Initial:

MEDICAL INFORMATION	
<b>* Drug Allergies:</b> <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> None <input type="checkbox"/> Sulfonamides <input type="checkbox"/> Other _____	<b>Health Conditions</b> (to monitor drug/disease interactions): <input type="checkbox"/> Arthritis <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Intestinal Disorder _____ <input type="checkbox"/> Glaucoma <input type="checkbox"/> Thyroid <input type="checkbox"/> Heart Condition <input type="checkbox"/> Lung Condition <input type="checkbox"/> Other _____

Please check if you have or your physician has already submitted any other prescriptions previously that you would like filled now.  
If so, please list here:

Would you like to receive a call from a pharmacist to counsel you on your medications or to discuss your medications with you?     YES     NO

METHOD OF PAYMENT	
<input type="checkbox"/> PLEASE CHECK HERE IF THIS IS A CREDIT CARD CHANGE.	
<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> American Express	
* Credit Card Number:	* Expiration Date:
* Name as it Appears on the Card:	* CVV Code (3 digits):
* Billing Address of Credit Card:	

SIGNATURES	
I certify that the patient information entered on this form is correct and I authorize the release of all information to the plan administrator. If the prescription coverage is denied, I agree to reimburse SCL Health Pharmacy Services for the amount of benefit which is being denied under the prescription plan. I also understand that all co-payments and/or prescription costs for products purchased through SCL Health Pharmacy Services will be charged to the credit card provided above. I understand by signing this form that prescription medications cannot be returned to the pharmacy for credit unless in response to a recall, defect in a medical device, or otherwise pre-approved by the pharmacy. A return of medication for any reason shall result in its immediate destruction and shall not be available for credit.	
* Authorization Signature: _____	* Date: _____
Please also sign below to indicate that you have accessed and reviewed the HIPAA Privacy Notice, which can be found under the Legal Notices section at <a href="http://www.sclhealthbenefits.org/plan-documents">www.sclhealthbenefits.org/plan-documents</a> .	
* Signature: _____	* Date: _____