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@sclhealth.org (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: ☐ Male ☐ Female	☐ Please no child-proof caps
* Home Phone #:	* Work Phone #:	* Cell Phone #:
* Email:		

PRESCRIPTION DELIVERY — * Check One or Both:

☐ New Prescription(s) — I understand my prescription(s) will be delivered to the Associate Health Center.	☐ 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): ☐ CDHP ☐ PPO
* Last Name:	* First Name:	* Initial:

MEDICAL INFORMATION

*** Drug Allergies:**

☐ Aspirin ☐ Penicillin ☐ Codeine

☐ None ☐ Sulfonamides ☐ Other ____________

Health Conditions (to monitor drug/disease interactions)**:**

☐ Arthritis ☐ High Blood Pressure ____________

☐ Diabetes ☐ Intestinal Disorder ____________

☐ Glaucoma ☐ Thyroid ☐ Heart Condition

☐ Lung Condition ☐ 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

☐ *PLEASE CHECK HERE IF THIS IS A CREDIT CARD CHANGE.*

☐ MasterCard ☐ Visa ☐ Discover ☐ 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 www.sclhealthbenefits.org/plan-documents.

* Signature: ______________________ * Date: __________