



Mail Order Pharmacy Enrollment/Change Form

- This form is to enroll a new patient.
- This form is to update information for an existing patient.

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)

Questions?

Call **303-689-6121** or
Toll Free **855-235-4301**

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	

SHIP TO THIS ADDRESS PLEASE CHECK HERE IF THIS IS A CHANGE OF ADDRESS.

* Street Address (no P.O. boxes please):		Apt. or Suite:	
* City:	* State:	* ZIP Code:	
* Home Phone #:	* Work Phone #:	* Cell Phone #:	
* Email:			

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

* Drug Allergies: <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> None <input type="checkbox"/> Sulfonamides <input type="checkbox"/> Other _____		Health Conditions (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 _____	
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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 (If applicable) 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 www.sclhealthbenefits.org/plan-documents.
* Signature: _____ * Date: _____