Mail Order Pharmacy Enrollment/Change Form

SCL Health

☐ 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@sclhs.net (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: ☐ Male ☐ Female	☐ 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): ☐ 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 (If applicable)

☐ *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: _____