

PBM PLUS MAIL ORDER PRESCRIPTION PLAN®

Administered by PBM PLUS

Enrollment Form

Please complete all information and print clearly so as to avoid delay in enrollment and your order.

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City: _____ State: ____ Zip: _____ - _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Gender: ____ Date of Birth: ____/____/____ Social Security* #: _____ - _____ - _____
M/F MM DD YYYY

* Social Security number will remain confidential. It is used to create a unique ID number but will not appear on your ID card.

DRUG ALLERGY AND DISEASE INFORMATION

Drug allergies: Penicillin __ Sulfa __ Other: _____ *

Disease conditions: Diabetes __ Thyroid __ High blood pressure __ Other: _____ *

*If additional space is needed please attach a separate piece of paper and indicate "continued" after Other.

The following credit card information is only necessary if you wish to have the first prescription(s) or subsequent prescriptions that you have filled through the PBM Plus Mail Service Prescription Plan® charged to your credit card.

CREDIT CARD INFORMATION

Credit Card Type: Master Card __ Visa __ Discover __

Credit Card Number: _____ Expiration Date: (mm/yy) ____/____

Cardholder Name on Credit Card: _____

When utilizing the PBM Plus Prescription Plan, I authorize PBM Plus. to charge the discounted cost of prescriptions filled for the above named individual to the credit card described above. I attest that I am a legal, authorized user of the designated card. I further agree that I will make all necessary payments to my credit card per my cardholder agreement. Charges made to my credit card will appear on my credit card statement as "PBM PLUS Prescription Benefit Program.

____ My initials here indicate that I want all prescriptions filled for the above named individual charged to this card and I want PBM Plus Mail Service Pharmacy to keep my credit card information on file for future use.

Cardholder Signature

Printed Name of Card Holder

Date

FOR OFFICE USE ONLY

Region: _____ OCR Facility Code: _____ Discharge Date: _____ Group Number: **INET**

Form received: _____ ID No: _____ Entered into system: _____

Return the completed form to PBM Plus Mail Service Pharmacy that provided this information or you may Mail or fax to the address or fax number provided below.