125 N Main St.
Concord NH 03301

Phone: 603-226-8686
Fax: 603-225-6579

PRESCRIPTION PACKAGING PROGRAM ENROLLMENT FORM

(please complete a separate form for each family member)

Case Management Agency	
Case Manager Name, e-mail, and Phone	

Step 1: Patient Information

Last Name:	First Name:	M. Initial:
Date of Birth:	Male ☐ Female ☐ SS #	
Home Address:		
City:	State:	Zip:
Shipping Address: (if different)		
City:	State:	Zip:
Home Ph:	Cell Ph:	
Emergency Contact or Care Giver		
Home Ph:	**Cell Ph:**	
Visiting Nurse Agency:		
Primary Care Physician:		
Psychiatrist:		
Other Specialist:		
Other Specialist:		

STEP 2: Insurance Information (Please attach a copy of Insurance card, front & back)

Subscriber Cardholder Name: (if different from Patient)	Relationship: ☐ self ☐ spouse ☐ child ☐ Other
Member Card ID #:	**Pharmacy BIN:** **PCN:**

STEP 3: Health Information

Medication Allergies ☐ YES ☐ NO	If YES, please list:
Medical Conditions: ☐ YES ☐ NO	If YES, please list:

STEP 4: Prescribed Medication Information Including Over the Counter				
MEDICATION NAME	Strength & Frequency (qty/day)	Doctor's Name	Doctor's Phone number	Last Refill Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

PATIENT AUTHORIZATION

☐ I certify that the information on this form is correct, and authorize release of information regarding my medical and prescription drug history to above care givers and Northeast Pharmacy Services, 125 N Main St, Concord, NH 03301, 603-226-8686.

Insurance Waiver: Beneficiary of responsible party has been notified that the above terms may not be medically necessary and has agreed to be responsible for all charges. This waiver will remain on file with Northeast Pharmacy Services.

_____ _____ _____

Signature/Representative | Relationship of Representative to Patient | Date

PAYMENT / BILLING INFORMATION

Payment is required prior to delivery. Please select your method of payment.

☐ Debit Card:

☐ Credit Card: ____ Visa ___ MasterCard ____ Discover ____ American Express

Name listed on card: _____ Credit Card #: _____ Exp. Date: _____

Signature: _____ Date: _____

☐ I authorize Northeast Pharmacy Services to bill my credit card. I understand that my credit card will be billed the following amounts in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or deductible amounts; payments due for medications or supplies not covered under my benefit plan, plus any shipping costs.