Alliance Meds

ENROLLMENT FORM

Contact us at: 1-866-929-8500

Fax completed form to: 570-467-3217

Or mail to:
Alliance Medication Services, LLC
P.O. Box 222, Barnesville, PA 18214

CLAIMANT'S INFORMATION:

Name: _____ ☐ Male ☐ Female
Last First Middle

Address: _____
Street City State Zip Code

Home Phone #: _____ Cell Phone #: _____ Email: _____

Date of Birth: _____ Social Security #: _____ _____ _____

Attorney's Name: _____ Phone #: _____

INJURY/INSURANCE CARRIER INFORMATION

Date of Injury: _____ Employer's Name: _____

Description of Work Injury: _____

Insurance Carrier's Name: _____ Phone #: _____

Address: _____
Street City State Zip Code

Claim Number: _____ Adjustor's Name: _____

MEDICAL INFORMATION

Allergies: ☐ None ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Aspirin ☐ Other: _____

Medications: _____

Physician's Name: _____ Physician's Phone #: _____

Address: _____
Street City State Zip Code

Referred by: ☐ Attorney ☐ Physician ☐ Other: _____

I certify that the information on this form is accurate and complete. I authorize payment of medical benefits to Alliance Medication Services, LLC. I hereby authorize any doctor, hospital or other provider who participated in my care and treatment to release to Alliance Medication Services, LLC all medical or other information requested for the processing of my claim(s).

Claimant's Signature: _____ Date: _____

For Internal Use Only:

Enrolled: _____ Verified: _____ Status: _____

Referred by: _____