Meds Alliance

ENROLLMENT FORM

Contact us at: 866-929-8500

Fax completed form to: 570-668-8825
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 #: (____) _____

Claim Number: _____ Adjustor's Name: _____

MEDICAL INFORMATION

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

Work Related Medications: _____

_____

Non-Work Related 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: ____/____/____