AllianceMeds Your Workers' Compensation Pharmacy Experts!

PO Box 222
Barnesville, PA 18214
866-929-8500
www.AllianceMeds.com

ELECTRONIC ENROLLMENT AND DELIVERY CONSENT FORM

Please complete this form as soon as possible or if you would prefer to enroll over the phone you can call our enrollment team toll free at 866-929-8500, option #3.

At AllianceMeds, we understand that taking the time to complete enrollment over the phone can be an inconvenience during your busy day. By completing and signing this form, we can collect the information we need, verify your medications, request the proper legal documents and establish delivery preferences all from the comfort of your phone or computer.

PATIENT'S INFORMATION

NAME: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

DATE OF BIRTH: ____ / _____ / _____ SOCIAL SECURITY #: _____-_____-_____

Identification #: _____
(Driver's License, State Issued Photo ID, Passport ID)

ATTORNEY'S INFORMATION

ATTORNEY NAME: _____ PHONE #: _____

MEDICAL INFORMATION

ALLERGIES: ☐ NONE ☐ PENICILLIN ☐ CODEINE ☐ SULFA ☐ ASPIRIN

☐ OTHER: _____

WORK-RELATED MEDICATION NAME #1: *(include quantity and dosage if possible)* _____

PRESCRIBED BY: _____ PRESCRIBER'S PHONE #: _____

END SUPPLY DATE: _____ STATUS OF PRESCRIPTION: *(Please select an option below)*

☐ Transfer from local pharmacy ☐ Request from provider ☐ Hard copy prescription in hand, I will mail*

WORK-RELATED MEDICATION NAME #2: *(include quantity and dosage if possible*) _____

PRESCRIBED BY: _____ PRESCRIBER'S PHONE #: _____

END SUPPLY DATE: _____ STATUS OF PRESCRIPTION: *(Please select an option below)*

☐ Transfer from local pharmacy ☐ Request from provider ☐ Hard copy prescription in hand, I will mail*

WORK-RELATED MEDICATION NAME #3: *(include quantity and dosage if possible*) _____

PRESCRIBED BY: _____ PRESCRIBER'S PHONE #: _____

END SUPPLY DATE: _____ STATUS OF PRESCRIPTION: *(Please select an option below)*

☐ Transfer from local pharmacy ☐ Request from provider ☐ Hard copy prescription in hand, I will mail*

WORK-RELATED MEDICATION NAME #4: *(include quantity and dosage if possible*) _____

PRESCRIBED BY: _____ PRESCRIBER'S PHONE #: _____

END SUPPLY DATE: _____ STATUS OF PRESCRIPTION: *(Please select an option below)*

☐ Transfer from local pharmacy ☐ Request from provider ☐ Hard copy prescription in hand, I will mail*

WORK-RELATED MEDICATION NAME #5: *(include quantity and dosage if possible*) _____

PRESCRIBED BY: _____ PRESCRIBER'S PHONE #: _____

END SUPPLY DATE: _____ STATUS OF PRESCRIPTION: *(Please select an option below)*

☐ Transfer from local pharmacy ☐ Request from provider ☐ Hard copy prescription in hand, I will mail*

If you have additional work-related medications, please list them below.

*Please fill out your local pharmacy information **ONLY** if you selected that there are available refills for any of your work-related medications.*

PHARMACY NAME: _____ LOCATION: _____ PHONE#: _____

* ☐ Please provide me with a self-addressed and stamped envelope so that I may mail in my hard copy prescription.

Please list all non-work-related medications so that our Pharmacy team can prevent possible drug interactions.

DELIVERY

Our preferred delivery method is UPS. UPS offers the fastest delivery to most locations and will attempt 3 deliveries before returning the medications our pharmacy. If your address is a PO Box and requires USPS delivery, please check box for postal. ☐ POSTAL

*By default, our deliveries require a signature by a recipient 21 years of age, or older. A signature is required when delivering Class medications. If you are **NOT** prescribed Class medications and you believe your location affords safe delivery, you may choose to remove the required signature.*

☐ Please leave the signature for delivery ☐ Please remove the signature for non-class medications delivery

For your convenience, we are able to provide you with the tracking information for your deliveries.

☐ Please send me tracking information via: *(please select one)*

Email: _____ **OR**

Text Message *(standard text rates may apply)* Cell Phone Carrier: _____

☐ I DO NOT wish to receive tracking information

Additional Information or Questions:

Please contact me with any future questions via: ☐ Phone call ☐ Text Message ☐ Email ☐ Mail

☐ By checking this box, I consent to the shipment of my work-related medications from AllianceMeds.

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 has 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).

_____ _____

Signature Date