

Prescription & Enrollment Form Infertility

(800) 962-6339 Office
(866) 755-6339 Fax



Patient Information

_____	_____
Last Name	First Name
_____	_____
Social Security #	Date of Birth
_____	_____
Parent or Guardian	
_____	_____
Home Phone	Other Contact Phone
_____	_____
Home Address	

City, State, Zip	

Insured Information

Primary Insurance (Fax copy of card – both sides)	

Subscribers Name	Relationship to Patient
_____	_____
Policy #	Group #
_____	_____
Primary Insurance Phone	

Prescription Card (Fax copy of card – both sides)	

Carrier	Policy #
_____	_____

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)

Primary Diagnosis	Secondary Diagnosis
_____	_____
Allergies	

Height _____ Weight _____	Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Diagnosis _____

PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity	Refills

DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other	Address _____	Date Medication Needed
	City/State/Zip _____	

Physician's Name (Please Print) _____

Physician's DEA# _____

Physician's Address _____

Physician's Signature _____

Date _____

Phone _____

Fax _____

License # _____

NPI # _____

Dr.'s Office Contact Name _____

Contact Phone # _____

Fax completed form to Medex BioCare (866) 755-6339