Enrollment Form

toll-free phone 855.611.3399
toll-free fax 855.423.8300

patient information

patient: ______________________ male / female DOB: __________ SS#: ______________
last name, first name

address: ____
street city state zip

primary phone number: ______________ cell alternate phone number: ______________ cell

caregiver: ______________________ allergies: ______________________ NKDA

comorbidities: ______________ height: ______ weight: ______ lbs / kg date: ______________

Diagnosis/ICD 9: ____

clinical information

*Complete this section ONLY if you would like Thrifty White Pharmacy to initiate a prior authorization or appeal on your behalf:

prior therapy	reason for discontinuation of therapy	year of discontinuation
	Disease Progression Finished Therapy Toxicity (please specify) ______________	

prescription

Medication Form/ Strength/ Dose/ Directions/ Frequency/ Quantity/ Refills

prescriber + shipping information

prescriber (print): ______________________ office contact: ______________

ship to: patient office alternate ______________________________
shipping address: street city state zip

office address: ____
(street, suite, city, state, zip)

phone: ______________ fax: ______________ NPI: ______________ DEA: ______________

prescriber's signature: ______________________________ date: ______________

I authorize Thrifty White Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

insurance information: please fax copy of insurance card (front + back)

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