



Enrollment Form



BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

CaremarkConnect®: 866-278-5108

Fax Referrals: 800-323-2445

Date: _____ Date Needed: _____ Please enter all dates as MM/DD/YYYY.

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Date of Birth: _____ Gender: M F

Weight: _____ lbs. kg.

PRESCRIBER INFORMATION

Prescriber's Name: _____

State License #: _____ UPIN: _____

DEA #: _____ NPI #: _____

Group or Hospital: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

Lab Data/Allergies/Additional Comments/ Concomitant Medications: _____

• Date of Diagnosis: _____

Injection Training/Home Health Coordination:

• Injection training/home health will be/has been conducted/coordinated by the physician's office. Yes Date: _____ No

• Specialty pharmacy to coordinate injection training/home health nursing. Yes No • Agency of Choice: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

PHYSICIAN'S SIGNATURE

(Date)

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