CVS CAREMARK

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:

• Date of Diagnosis: _____

Lab Data/Allergies/Additional Comments/ Concomitant Medications:

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

Reset

PHYSICIAN'S SIGNATURE (Date)