

University of Wisconsin Specialty Rx90 Pharmacy Enrollment Form

ENROLLMENT INFORMATION

Name (last, first): _____
Date of birth: _____ UW Medical Record # (if available) _____
Daytime phone: () _____ Evening phone: () _____
Home address: _____
City: _____ State: _____ Zip: _____
Shipping address: _____ City/State/Zip: _____
Any known allergies: ___ No ___ Yes, list

PRESCRIPTION NUMBER	NAME OF DRUG	DOSE	PHARMACY NAME AND NUMBER	PHYSICIAN NAME AND NUMBER

INSURANCE INFORMATION

PRIMARY *Please provide a front and back copy of your prescription insurance card (or fill out the information below)
Prescription Insurance Coverage: _____ Patient's relationship to policy holder: _____
Subscriber#: _____ Group#: _____ Person Code: _____
Name of Policy Holder: _____

SECONDARY

Prescription Insurance Coverage: _____ Patient's relationship to policy holder: _____
Subscriber#: _____ Group#: _____ Person Code: _____
Name of Policy Holder: _____

CREDIT CARD/E-CHECK INFORMATION (if applicable)

Type of credit card: ___ Master Card ___ Visa Cardholder Name: _____
Credit Card Number: _____ Exp. Date _____
Cardholder Signature: _____ Date: _____
By signing, I authorize UWHC Pharmacy to charge my pharmacy expenses to my credit card.

OR

Type of account: ___ Checking ___ Savings Account Holder Name: _____
Name of bank: _____ Routing #: _____ Account#: _____
Account Holder Signature: _____ Date: _____
By signing, I authorize UWHC Pharmacy to charge my pharmacy expenses to my checking/savings account.

UWHC MAIL ORDER/DELIVERY TERMS AND CONDITIONS

- 1) I understand that upon receipt of an order, I am responsible for ensuring that UWHC Pharmacy is reimbursed for the full amount of the purchase.
- 2) I understand that items purchased are nonreturnable.
- 3) I understand that UWHC pharmacy will bill my insurance carrier directly, however my credit card will be billed for insurance copayments, applicable shipping and handling fees, requested over-the-counter products and prescriptions not covered by insurance.
- 4) **By signing below, I certify that I have read and agree with the above terms and conditions.**

Member Signature: x _____ Date: _____

Please Forward This Completed Form by One of the Following Options:

- 1.) Fax this completed form to: (608)-265-1696, or
- 2.) Call 263-1292 (local) or Toll Free **866-UWH-DRUG** (866-894-3784) to enroll over the phone, or
- 3.) Mail this completed form to the following address: University of Wisconsin Hospital and Clinics

Mail Service Pharmacy
5249 E Terrace Dr
Madison, WI 53718

THANK YOU FOR CHOOSING UWHC TO CARE FOR YOUR PHARMACEUTICAL NEEDS!