



CuraScript Pharmacy

Prescription Enrollment Form

Fax: 888.773.7386

Phone: 888.773.7376

Last Name	First Name	Home Phone Number	Work Phone Number	Today's Date	Date Needed		
Parent / Guardian				Physician's Name (please print)	Hospital / Clinic		
Home Address	City	State	Zip	Address	City	State	Zip
Shipping Address (If different from home address)				Phone Number	Fax Number		
Social Security Number		Date of Birth		Office Contact			

Allergies
Special Instructions (Non-English Speaking Patients, etc.)

Primary Insurance Company	Phone	Name of Insured / SSN	Employer Name / ID Number	Group Number
Secondary / Supplemental Insurance Company	Phone	Name of Insured / SSN	Employer Name / ID Number	Group Number

Medication: _____	Medication: _____	Medication: _____
Direction of Use: _____	Direction of Use: _____	Direction of Use: _____
Quantity: _____ Refill x _____ month(s)	Quantity: _____ Refill x _____ month(s)	Quantity: _____ Refill x _____ month(s)

Delivery Instructions: Home Work Other

Physician's Signature: _____ **UPIN # / DEA** _____

Statement of Medical Necessity
 Primary Diagnosis: _____ ICD 9 Code _____
 Medical History: _____
 Estimated Start of Therapy: _____

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS