

# 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!**