

DickinsonCRX

CRX International Member/Spouse/Dependent Enrollment Form

SSN #: _____

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-215-7874
Or MAIL TO: DickinsonCRX, P.O. BOX 44650, DETROIT, MI 48244-0650 PHONE TOLL-FREE: 1-866-488-7874

PATIENT INFORMATION:

Birthdate _____

DD/MM/YYYY

Phone (Home) _____

Phone (Work or Cell) _____

First Name (please print) _____

Initial _____

Last Name _____

Street Address _____

City/State _____

Zip Code _____

***NOTE:** Please request a **3-month** supply of medication with **3 refills**.

***New-to-you** medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements.

*Ex. Crestor**(This is NOT a prescription.)*

Strength

Ex. 10 mg

Reason for Taking

Ex. Cholesterol

Daily Use

Ex. One a day

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.)

 Male Female

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(ii) Hospitalizations: (stays in hospital during the past 5 years) _____

(iii) Present Illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(iv) Drug Allergies: NO YES If yes, please specify: _____**AUTHORIZATION IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18**

I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent's/Guardian's Signature: _____

Date: (DD/MM/YY)

AUTHORIZATION IF THE PATIENT IS THE MEMBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER

I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient Signature: _____

Date: (DD/MM/YY)