QoL Meds Enrollment Form

CMHC Location____________________ Date of Enrollment________________

Personal Information

Client Full Name____

Complete Address____

Phone Number_______________________ Date of Birth____________________ Sex: M F

Social Security Number________________________________ Case Manager's Name______________________

Known Drug Allergies____

Known Medical Conditions____

___PickUp Meds at site or ___ Mail Meds to above address

Secondary contact Name/Phone # ____

Insurance Information

Primary Insurance name_______________________________ Bin #_______________________

ID #________________________________ Group #_________________________ PCN#____________________

Secondary Insurance name________________________ Bin #________________ PCN #__________________

ID #_______________________________________ Group#__________________________

Payee Name & phone #____

Doctor Information

Psychiatrist's Name:_________________________________ Ph #________________________________

Primary Care Physician______________________________ Ph #________________________________

By signing below I: give QoL meds permission to provide/obtain confidential health info from my doctor(s) or other necessary third parties; I acknowledge receipt of QoL Meds notice of privacy practices; and choose QoL Meds as my pharmacy of choice.

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(sign) (date)