Miscellaneous ENROLLMENT FORM

Vital Care Rx
Please Fax Enrollment forms to:
(877) 229-1725
To speak with someone at Vital Care Rx:
(877) 229-1724

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Alt Phone: _____

DOB: _____ SSN: _____

☐ Male ☐ Female

Deliver Medications To: ☐ Patient's Home ☐ Clinic

Primary Insurance: _____

ID # _____ Group # _____

PRESCRIBER INFORMATION

Prescriber Name: _____

Office Contact: _____

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Ext: _____

Fax Number: _____

NPI: _____

FAX COPY OF INSURANCE CARD FRONT AND BACK

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Diagnosis: ☐ ICD 9 - _____
☐ ICD 9 - _____
☐ ICD 9 - _____
☐ ICD 9 - _____

Allergies: _____

Weight: _____ Height _____ BSA _____

Expected date of first/next dose: _____ Date of last dose: _____

PRESCRIPTION INFORMATION

Medication	Directions		Quantity	Refills
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

Special Instructions -

Injection Training Needed ☐ **Yes** ☐ **No**

Prescriber Signature _____ Date _____ Brand Name Required? ☐ Yes

By signing this form and utilizing our services, you are authorizing Vital Care Rx and its employees to serve as your prior authorization designated agent with medical and prescription insurance companies.