MedExpress℠ PHARMACY

Easy Enrollment Form

PO Box 1666
Salisbury, NC 28145
Tel: 1-800-808-8060
Fax: 1-800-808-6331
www.1800medexpress.com

MEMBER DETAILS

First Name	MI	Last Name	SSN	Home Phone

Address			Date of Birth	Cell Phone
City	State	Zip	Male ☐ Female ☐	Work Phone
Shipping Address (If different from Home Address)			May we email shipment info? Yes ☐ No ☐	Email Address
City	State	Zip	Best Time of Day to Call	May we leave a message? Yes ☐ No ☐

INSURANCE DETAILS *(Please Attach Copy of Insurance Card, Front and Back)*

Are You the Policy Holder? Yes ☐ No ☐	Type of Insurance: Insurance ☐ Medicaid ☐ ADAP ☐ Other ☐	**If you are the policy holder, you may skip to the next section.**

Policy Holder Name	Relationship to Policy Holder	Policy Holder Date of Birth	Policy Holder SSN

PHYSICIANS & CASE MANAGEMENT

Primary Physician	Phone Number
Physician	Phone Number
Physician	Phone Number

Case Manager	Organization	Phone Number

MEDICATION LIST *(Attach Additional Sheet if Necessary)*

Medication Name	Strength	Quantity	Directions	Prescribing Physician

Do you have any allergies or sensitivities to food or drugs? Please Explain.

Applicant Signature	Date

Your signature certifies that all information contained herein is true and accurate.

Print Form

ASSIGNMENT OF BENEFITS,
LIMITED POWER OF ATTORNEY, AUTHORIZATIONS & HIPAA

Member Name: _____

The undersigned Member hereby assigns to MedExpress all of Member's rights including but not limited to Member's right to collect, receive, adjudicate, negotiate, compromise, and discuss any and all amounts due Member for services and products provided to Member by MedExpress. Member specifically authorizes and directs Member's insurance company, third party insurance processor, attorney, attorney-in-fact, guardian, or other Payer ("Payer") to remit directly to MedExpress all payments Member now owes or may hereafter owe for said services and products. _____ Initial

Member hereby assigns and transfers to MedExpress any cause and action that exists in Member's favor against Payer. Member expressly authorizes MedExpress to prosecute said action either in Member's name or in MedExpress' name and further authorizes MedExpress to compromise, settle, or otherwise resolve said claim. _____ Initial

Member hereby authorizes MedExpress to release any information concerning Member deemed reasonably appropriate to any Payer, attorney, or adjuster necessary to process any claim for reimbursement for charges incurred by Member for professional services rendered by MedExpress. Member hereby releases MedExpress from any liability or consequence related to any such release. _____ Initial

This assignment is intended to constitute a grant by Member to MedExpress a Special Power of Attorney pursuant to Chapter 32 of the North Carolina General Statutes to act on Member's behalf as a fiduciary for Member for the assignments indicated herein as well the authority to communicate with Member's Payer on all matters, including but not limited to:

- Verification of Member's prescription coverage with Member's Payer,
- Information regarding any and all remittances for services and products provided by MedExpress to Member including but not limited to information regarding: when any such amount was remitted, addressee of the remittance, address to which such remittance was sent, whether such remittance was negotiated and if so, by whom and on what date, whether such remittance has cleared the Payer's bank or financial institution. _____ Initial

Member authorizes MedExpress to discuss with member's physicians, case managers, or other related healthcare providers any matter relating to Member's prescriptions or medication regimen so long as such communication is within the scope of MedExpress' duties and responsibilities as Member's pharmacy. _____ Initial

Signature: _____ Date: _____

HIPAA ACKNOWLEDGEMENT

The signature of the Member, guardian, or the authorized legal representative of the Member certifies, on behalf of the Member, that MedExpress Pharmacy ("Pharmacy") has provided the Member with a copy of the Pharmacy's Notice of Privacy Practices (Notice). This Notice explains the uses and disclosures of protected health information (PHI) that may be made by the pharmacy as well as the Member's rights and the pharmacy's duties with respect to PHI.

Signature: _____ Date: _____