RxOutlet Pharmacy

Patient Registration Form

10 Meadowlands Pkwy • Secaucus, NJ 07094 Toll free:
866-699-8239 • Toll free fax 407-681-2726

www.RxOutlet.com

Mail of fax the completed for to the address or fax listed above. **IMPORTANT: Attach your prescription(s) along with the completed patient registration form.**

PATIENT INFORMATION

First:	Last:	M.I.:
Address:		
City:	State:	Zip:
Date of Birth:	☐Male ☐ Female	SSN:
Best Phone:	Alt. Phone:	Email:

INSURANCE INFORMATION

Do you have Medicare? ☐YES ☐ NO	Medicare ID#:	
Prescription Insurance Company:		Phone:
BIN #:	PCN #:	ID #:
Group#	Additional Information:	

DRUG AND FOOD ALLERGIES

☐ Codeine (32)	☐ Sulfa (87)	☐ Penicillin (70)	☐ Tetracycline (93)	☐ Other (00)
List Other Allergies:				

HEALTH CONDITIONS

☐ Diabetes (200)	☐ Hypertension (300)	☐ Heart Disease (400)	☐ Glaucoma (500)	☐ Digestive Disorder (600)
☐ Thyroid Disorder (700)	☐ Arthritis (800)	☐ Unknown (000)	☐ Other (000)	
Other Health Conditions:				

MEDICATIONS AND SUPPLEMENTS

Please list all medications and supplements that you are currently taking:

PHYSICIAN INFORMATION

First:	Last:	
Phone:	Alt. Phone:	Fax:

ADDITIONAL COMMENTS

Is there anything else that you would like us to know so that we may better serve you:

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www.WellsSpecialtyPharmacy.com

PRESCRIPTION TRANSFER INFORMATION

Please complete this section only if you are transferring your prescription(s) from your current pharmacy to RxOutlet. Your prescriptions must be transferred from you current pharmacy to RxOutlet Pharmacy in order to participate in the Patient Assistance Program. Prescription(s) must be written for a 90 day supply.

**New York State Residents: Our pharmacy staff can transfer one refill from your home pharmacy. If more than one refill is required, the prescribing clinician must authorize the transfer.

Would you like us to transfer the attached prescriptions from your current pharmacy to Wells Specialty Pharmacy? ☐ YES ☐ NO

Current Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

MEDICATIONS TO BE TRANSFERRED

MEDICATION	Rx NUMBER	MEDICATION	Rx NUMBER

☐ **Check here if you authorize pharmacist to substitute for generic medication**

METHOD OF PAYMENT

Payment Type: ☐ Check ☐ Credit Card	☐ AMEX ☐ VISA ☐MASTERCARD ☐ DISCOVER	
Cardholder Name:		
Cardholder Address:		☐ Same as above
City:	State:	Zip:
Card Number:	Expiration Date: _____/_____	CVV Code:

SHIPPING OPTIONS

Please select one:	☐ Standard Shipping $3.85	☐ 2-3 Day Shipping $25.00	☐ Overnight Shipping $45.00

☐ Signature Required Option $3.00

My signature below authorizes RxOutlet Pharmacy to administer the following:

1. Use any information that I provide in this registration form to enroll in the RxOutlet Pharmacy Patient Assistance and Mail Order program.
2. Receive and keep records of all prescriptions for the medications I receive under the program.
3. Contact my doctor(s), health care provider(s), and/or pharmacist about my registration for the program, and disclose to the information contained in this registration form.
4. Request information from my insurer(s), physician(s), health care provider(s), and/or pharmacist about the prescribed medications I receive or will receive while enrolled in the program and about my medical condition. By signing below, I authorize my insurer(s), physician(s), health care provider(s), and/or pharmacist to release information about my prescribed medications and medical condition that is requested by RxOutlet Pharmacy.
5. Contact my insurer(s) and other potential funding sources on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in this registration form or information about my prescribed medications and medical condition that has been provided by my physician(s), health care provider(s), and/or pharmacist.
6. I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I am enrolled and participate in the program and for a period of three (3) years after my participation in the program ends. Furthermore, I certify that the information provided on this registration form is complete and accurate to the best of my knowledge and agree to notify RxOutlet Pharmacy of any change in my insurance eligibility.
7. By submitting this application, I confirm that I have read, understand, and agree to the RxOutlet Pharmacy privacy policy posted at: http://www.RxOutlet.com

PATIENT SIGNATURE:	**DATE:**