

FOR PATIEN	
Patient Information	
First Name: SQ //Y	Last Name: SmjHh
Gender: Male Female Date of Birth: 9/23/75	ssn: 404-04-0404
Address: 4816 Warbler Way City, St	ate: LAII. KY 710. 40213
Phone: 502 555-7878 Home Mobile	work Email: SSMithegmail.com
	Contact: Morning Afternoon Evening
Insurance Information	See attached insurance ca
Insurance Name: ALTNA	Phone: 800 872-3862
Plan ID #: 102442551 Group #: 923382	
Policy Holder Name: (If different from patient) Brian Smith	Policy Holder DOB: 11/30/73
FOR PHYSICIAN (DNLY
Physician Information	ONLY
Physician Information	Specialty: Cayn OnC
Physician Information Physician Name: Daniel Metzinger NOTE: 1016340171	
Physician Information Physician Name: Daniel Metzinger NPI#: 106340171 License #(s): Facility Name: Voft Oncology	Specialty: Gryn OnC Group Tax #:
Physician Information Physician Name: Daniel Metzinger NPI #: 106340171 License #(s): Facility Name: Voft Oncology Address: 529 5 Jackson St City, Sta	Specialty: Gryn OnC
Physician Information Physician Name: Daniel Metzinger NPI#: 106340171 License #(s): Facility Name: Voft Oncology Address: 529 5 Jackson St City, Sta	Specialty: Gryn OnC Group Tax #: te: Lou, KY zip: 40202 : (502) 56/~ 7327
Physician Information Physician Name: Daniel Metzinger NPI #: 106340171 License #(s): Facility Name: Voft Oncology Address: 529 5 Jackson St City, Sta Phone: S02 561-7220 Fax	Specialty: Gryn OnC Group Tax #: te: Lou, KY zip: 40202 : (502) 56/~ 7327
Physician Information Physician Name: Daniel Metzinger NPI#: 106340171 License #(s): Facility Name: Vof L Oncology Address: 529 5 Jackson St City, Sta Phone: 502 561-7220 Fax Office Contact Name: Lance Rudolph	Specialty: Gryn OnC Group Tax #: te: Lou, Ky zip: 40202 : 502 56/- 7327 Contact Email: rudolph@gmail.com
Physician Information Physician Name: Daniel Met zinger NPI#: 106340171 License #(s): Facility Name: Voft Oncology Address: 529 5 Jackson St City, Sta Phone: S02 561-7220 Fax Office Contact Name: Lance Rudolph Clinical Information	Specialty: Gryn OnC Group Tax #: te: Lou, Ky ZIP: 40202 : 502 56/- 7327 Contact Email: rudolphe gmail.com
Physician Information Physician Name: Daniel Met zinger NPI#: 106340171 License #(s): Facility Name: Vof L Oncology Address: 529 S Jackson St City, Sta Phone: 502 561-7220 Fax Office Contact Name: Lance Rudolph Clinical Information Diagnosis Code (ICD-10): C.541 Diagnosis Description	Specialty: Gryn OnC Group Tax #: te: Lou, Ky zip: 40202 : 502 56/- 7327 Contact Email: rudolph@gmail.com
Physician Information Physician Name: Daniel Met zinger NPI#: 106340171 License #(s): Facility Name: Vof L Oncology Address: 529 S Jackson St City, Sta Phone: 502 561-7220 Fax Office Contact Name: Lance Rudolph Clinical Information Diagnosis Code (ICD-10): C541 Diagnosis Description	Specialty: Gryn OnC Group Tax #: te: Lou Ky zip: 40202 : 502 56/~ 7327 Contact Email: rudolph@gmail.com
Physician Information Physician Name: Daniel Met zinger NPI #: /06340/7/ License #(s): Facility Name: Vof L Oncology Address: 529 S Jackson St City, Sta Phone: S02 S61-7220 Fax Office Contact Name: Lance Rudolph Clinical Information Diagnosis Code (ICD-10): C54/ Diagnosis Description Prescription Rx: Medicine A Medicine B Medicine C	Specialty: Gryn Onc Group Tax #: te: Lou, Ky zip: 40202 : 502 56/- 7327 Contact Email: / rudo/ph @ gmail.com



	FOR PATIENT
Patient Information	,
First Name: Bella	MI: Last Name: Jennings
Gender: Male Female Date of Birth:	V
Address: 5010 Cotchele	City, State: LOU. KY ZIP: 4024/
Phone: 555 - 326-1746 Home	Mobile Work Email:
Best Method to Contact: Call Text Email	Best Time to Contact: Morning Afternoon Evening
Insurance Information	See attached insurance car
Insurance Name: Aethor HMO	Phone:
Plan ID #: Group #:	Is this a secondary plan?: Yes No
Policy Holder Name: (if different from patient)	Policy Holder DOB;
Plan Type: Private/Commercial Medicare Part D Medicare	Advantage Medicaid VA or Military Uninsured
	OR PHYSICIAN ONLY
Physician Information	
Physician Name: Shannon O'Brien	Specialty: On Cology
NPI #: //54567675	License #(s):
Facility Name: Norton Health East	Group Tax #:
Address: 239 Hufffville Crosskeys Rd	City, State: Sewell, NJ zip: 08080
Phone: 856 728-3636	Fax:
Office Contact Name: Jane Smith	Contact Email:
Clinical Information	
Diagnosis Code (ICD-10): C 4490 Dia	agnosis Description:
Prescription	
Rx: Medicine A Medicine B Medicine C	
Dosage: 2 pills, twice daily quantity:	28 days Refills: / [
I certify that the information above is accurate and medically necessary to the best of my knowith the information required to consent to this medication. I authorize the release of this information required to consent to the medication.	wiedge. I certify that I am the prescriber of this medication to the aforementioned patient and that I provided the patient ormation to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the
Physician Signature: Shannon O'Bruen	1/12/21



FOR PATIENT	
Patient Information	
First Name: Amy MI: Last Na	ime: Cummins
Gender: Male Female Date of Birth: 6/1/48	SSN:
Address: 4962 Spring St City, State: Sew	e//, NJ zip: 08080
Phone: 555 - 638-2046 Home Mobile Work	Email:
Best Method to Contact: Call Text Email Best Time to Contact:	Morning Afternoon Evening
Insurance Information	See attached insurance ca
Insurance Name: MECICATE	Phone: (
Plan ID #: 86346 Group #: 546921	Is this a secondary plan?: Yes No
Policy Holder Name: (If different from patient)	Policy Holder DOB:
Plan Type: Private/Commercial Medicare Part D Medicare Advantage Medicaid	VA or Military Uninsured
	J. G. Fillisured
FOR PHYSICIAN ONLY	
Physician Information	
Physician Name: Shannon O'Brien	Specialty: On Cology
NPI #: // 54567675 License #(s):	O1
Facility Name: Norton Health Elist	Group Tax #:
Address: 239 HUSFIVILLE Crosskeys Rd city, State: Sew	WII, NJ ZIP: 0808)
Phone: \$56 728-3636 Fax:	1
Office Contact Name: Jane Smith	Contact Email:
Clinical Information	
Diagnosis Code (ICD-10): C 4490 Diagnosis Description:	
Prescription	
Rx: Medicine A Medicine B Medicine C	
Dosage: 2 pills, twice daily quantity: 28 days	Refills: /
I certify that the information above is accurate and medically necessary to the best of my knowledge. I certify that I am the prescriber of with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to a patient's selected pharmacy.	if this medication to the aforementioned patient and that I provided the patient act on my behalf for the purposes of transmitting this prescription to the
Channan ATR	//2/21
Physician Signature: 0/W///01/ O Buon	Date: ///3/2/



Perspective3 • Enrollment Form

	FOR PATIENT		
Patient Information			
First Name: Marc	MI:	Last Name: Jimenez	<u>2_</u>
Gender: Male Female Date of Birth	11/30/73	SSN:	Control of the American Contro
Address: 4382 W Havens	کر City, Sta		710: 4/01/.3
0 1 10	Home Mobile V		217. /0/05
Best Method to Contact: Call Lext Email			Evening
Insurance Information			See attached insurance card
Insurance Name: Anthem		Phone:	
Plan ID #: Gi	roup #:	Is this a secondar	ry plan?: Yes No
Policy Holder Name: (if different from patient)		Policy Holder DOB:	
Plan Type: Private/Commercial Medicare Part D	Medicare Advantage Me	dispid VA or Military D II	
		dicaid	a
	FOR PHYSICIAN O	NLY	
Physician Information			
Physician Name: Shannon O'Bri	ien	Specialty: On	cology
NPI#: //54567675	License #(s):		
Facility Name: Norton Health East		Group Tax #:	
Address: 239 HUSFFVILLE Crosska	VS Rd City, State	: Sewell, NJ	zip: 08080
Phone: 856 728-3636	Fax:		2
Office Contact Name: Jane Smith		Contact Email:	
		Control of the Contro	
Clinical Information			
Diagnosis Code (ICD-10): C449D	Diagnosis Description:		
Prescription			
Rx: Medicine A Medicine B Medicine C			
Dosage: 2 pills, twice daily a	uantity: 28 days	Refills:	/ [
I certify that the information above is accurate and medically necessary to the with the information required to consent to this medication. I authorize the rel patient's selected pharmacy.	best of my knowledge. I certify that I am lease of this information to the manufactur	the prescriber of this medication to the aforementio rer for them to act on my behalf for the purposes of	ned patient and that I provided the patient transmitting this prescription to the
Physician Signature: Shannon O'Bu	ien	Date	1/13/21



FOR PATIENT	
Patient Information	
First Name: Stephanie MI:	Last Name: Compton
Gender: Male Female Date of Birth: 2/9/7/	SSN:
Address: 52/7 Silverten Ln City, State:	LOU KY ZIP: 4024/
Phone: Home Mobile Work	Email:
Best Method to Contact: Call Text Email Best Time to Contact	act: Morning Afternoon Evening
Insurance Information	See attached insurance car
Insurance Name: HUMANA	Phone:
Plan ID #: Group #:	Is this a secondary plan?: Yes No
Policy Holder Name: (If different from patient.)	Policy Holder DOB:
Plan Type: Private/Commercial Medicare Part D Medicare Advantage Medicare	
Medicare Part D Medicare Advantage Medicare Medicare Part D Medicare Advantage Medicare	d Uninsured
FOR PHYSICIAN ONLY	
Physician Information	
Physician Name: Shannon O'Brien	Specialty: On Cology
NPI #: // 54567675 License #(s):	Specialty: On Cology
NPI#: //54567675 License #(s): Facility Name: Norton Health East	Specialty: On Cology Group Tax #:
NPI #: // 54567675 License #(s):	Group Tax #:
NPI#: //54567675 License #(s): Facility Name: Norton Health East	Group Tax #:
NPI#: //54567675 License #(s): Facility Name: Norton Health East Address: 239 Hurffville (rosskeys Rd city, State:	Group Tax #:
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Huffville (rosskeys Rd city, State: Phone: 856 728-3636 Fax:	Group Tax #: Sewell, NJ zip: 08080
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Hufffville (rosskeys Rd city, State: Phone: 856 728-3636 Office Contact Name: Jane Smith Clinical Information	Group Tax #: Sewell, NJ zip: 08080
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Huffville (rosskeys Rd city, State: Phone: \$56 728-3636 Fax: Office Contact Name: Jane Smith	Group Tax #: Sewell, NJ zip: 08080
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Hufffville (rosskeys Rd city, State: Phone: 856 728-3636 Office Contact Name: Jane Smith Clinical Information	Group Tax #: Sewell, NJ zip: 08080
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Huffville (rosskeys Rd City, State: Phone: 856 728-3636 Fax: Office Contact Name: Jane Smith Clinical Information Diagnosis Code (ICD-10): C4490 Diagnosis Description: Prescription Rx: Medicine A Medicine B Medicine C	Group Tax #: Sewell, NJ zip: 08080
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Huffville (rosskays Rd city, State: Phone: 856 728-3636 Fax: Office Contact Name: Jane Smith Clinical Information Diagnosis Code (ICD-10): C4490 Diagnosis Description: Prescription	Group Tax #: Sewell, NJ zip: 08080
NPI#: //54567675 Facility Name: Norton Health East Address: 239 Huffville (rosskeys Rd City, State: Phone: 856 728-3636 Fax: Office Contact Name: Jane Smith Clinical Information Diagnosis Code (ICD-10): C4490 Diagnosis Description: Prescription Rx: Medicine A Medicine B Medicine C	Group Tax #: Sewell, NJ zip: 08080 Contact Email: