Perspective3 • Enrollment Form

Sample for Demonstrative Purposes

FOR PATIENT

Patient Information

First Name: Sally MI: M Last Name: Smith

Gender: ☐ Male ☑ Female Date of Birth: 9/23/75 SSN: 404-04-0404

Address: 4816 Warbler Way City, State: Lou. KY ZIP: 40213

Phone: (502) 555-7878 ☑ Home ☐ Mobile ☐ Work Email: ssmithe gmail.com

Best Method to Contact: ☑ Call ☐ Text ☐ Email Best Time to Contact: ☐ Morning ☐ Afternoon ☑ Evening

Insurance Information

☐ See attached insurance card

* Insurance Name: Aetna Phone: (800) 872-3862

Plan ID #: 102442551 Group #: 923382 Is this a secondary plan?: ☐ Yes ☑ No

Policy Holder Name: (If different from patient) Brian Smith Policy Holder DOB: 11/30/73

Plan Type: ☑ Private/Commercial ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA or Military ☐ Uninsured

FOR PHYSICIAN ONLY

Physician Information

Physician Name: Daniel Metzinger Specialty: Gyn Onc

NPI #: 1063401711 License #(s):

Facility Name: UofL Oncology Group Tax #:

Address: 529 S Jackson St City, State: Lou, KY ZIP: 40202

Phone: (502) 561-7220 Fax: (502) 561-7327

Office Contact Name: Lance Rudolph Contact Email: lrudolphe gmail.com

Clinical Information

Diagnosis Code (ICD-10): C541 Diagnosis Description:

Prescription

Rx: ☑ Medicine A ☐ Medicine B ☐ Medicine C

Dosage: 2 caps, BID mg Quantity: 28 days Refills: 4

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 this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: Daniel Metz Date: 2/10/21

Perspective3 • Enrollment Form

Sample for Demonstrative Purposes

FOR PATIENT

Patient Information

First Name: Bella MI: Last Name: Jennings

Gender: ☐ Male ☑ Female Date of Birth: SSN:

Address: 5010 Cotehele City, State: Lou. KY ZIP: 40241

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 card

Insurance Name: Aetna 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

FOR PHYSICIAN ONLY

Physician Information

Physician Name: Shannon O'Brien Specialty: Oncology

NPI #: 1154567675 License #(s):

Facility Name: Norton Health East Group Tax #:

Address: 239 Huffville 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): C4490 Diagnosis Description:

Prescription

Rx: ☑ Medicine A ☐ Medicine B ☐ Medicine C

Dosage: 2 pills, twice daily Quantity: 28 days Refills: 11

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 this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: Shannon O'Brien Date: 1/13/21

Perspective3 • Enrollment Form

Sample for Demonstrative Purposes

FOR PATIENT

Patient Information

First Name: Amy MI: Last Name: Cummins

Gender: ☐ Male ☑ Female Date of Birth: 6/1/48 SSN:

Address: 4962 Spring St City, State: Sewell, 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 card

Insurance Name: Medicare Phone:

Plan ID #: B6346 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

FOR PHYSICIAN ONLY

Physician Information

Physician Name: Shannon O'Brien Specialty: Oncology

NPI #: 1154567675 License #(s):

Facility Name: Norton Health East Group Tax #:

Address: 239 Huffville 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): C4490 Diagnosis Description:

Prescription

Rx: ☑ Medicine A ☐ Medicine B ☐ Medicine C

Dosage: 2 pills, twice daily Quantity: 28 days Refills: 11

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 this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: Shannon O'Brien Date: 1/13/21

Perspective3 • Enrollment Form

Sample for Demonstrative Purposes

FOR PATIENT

Patient Information

First Name: Marc MI: Last Name: Jimenez

Gender: ☑ Male ☐ Female Date of Birth: 11/30/73 SSN:

Address: 4382 W Havens Dr City, State: New Palestine, IN ZIP: 46163

Phone: 317-649-8895 ☐ Home ☑ Mobile ☐ Work Email:

Best Method to Contact: ☐ Call ☑ Text ☐ Email Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Insurance Information

☐ See attached insurance card

Insurance Name: Anthem 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

FOR PHYSICIAN ONLY

Physician Information

Physician Name: Shannon O'Brien Specialty: Oncology

NPI #: 1154567675 License #(s):

Facility Name: Norton Health East Group Tax #:

Address: 239 Hurffville 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): C4490 Diagnosis Description:

Prescription

Rx: ☑ Medicine A ☐ Medicine B ☐ Medicine C

Dosage: 2 pills, twice daily Quantity: 28 days Refills: 11

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 this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: Shannon O'Brien Date: 1/13/21

Perspective3 • Enrollment Form

Sample for Demonstrative Purposes

FOR PATIENT

Patient Information

First Name: Stephanie MI: Last Name: Compton

Gender: ☐ Male ☑ Female Date of Birth: 2/9/71 SSN:

Address: 5217 Silverton Ln City, State: Lou KY ZIP: 40241

Phone: ☐ Home ☐ Mobile ☐ Work Email:

Best Method to Contact: ☐ Call ☐ Text ☐ Email Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Insurance Information

☐ See attached insurance card

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 ☐ Medicaid ☐ VA or Military ☐ Uninsured

FOR PHYSICIAN ONLY

Physician Information

Physician Name: Shannon O'Brien Specialty: Oncology

NPI #: 1154567675 License #(s):

Facility Name: Norton Health East Group Tax #:

Address: 239 Hurffville 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): C4490 Diagnosis Description:

Prescription

Rx: ☑ Medicine A ☐ Medicine B ☐ Medicine C

Dosage: 2 pills, twice daily Quantity: 28 days Refills: 11

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 this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: Shannon O'Brien Date: 1/13/21