



filled by
 Anthem Prescription Management, LLC
 P.O. Box 746000
 Cincinnati, OH 45274-6000
 Telephone: 1-800-962-8192

For office use only—Input Code:

Enrollment Form

Part 1: Primary Cardholder Information

Cardholder I.D. Number (usually found on your benefit card):

Federally-approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, their physician or their health plan. Please use comment field on the back of the form to specify this request.

Plan Name

Last Name

First Name

Initial

Date of Birth

/ /

Sex

Male Female

Please list your complete shipping address below. Additional addresses can be added at any time.

Street Address

Apt./Suite #

City

State

ZIP

Day Phone Number (include Area Code)

() -

Evening Phone Number (include Area Code)

() -

Area Code

Area Code

Email Address:

New Prescriptions (Please provide the following information.)

Name

Date of Birth

/ /

Doctor's Name

Name

Date of Birth

/ /

Doctor's Name

Additional Refills (Please write your prescription number(s) in the boxes provided.)

Rx# Medication Name _____ Rx# Medication Name _____

Payment Information

Payment is required at time of shipment. A \$25 fee is charged for all returned checks. Please allow 14 days from the date you mail your order for the delivery of your medication. If you prefer expedited shipping, please mark the appropriate oval below. Expedited shipping applies only to the shipping time for your order, and in-house processing times will apply. Expedited shipping fees are subject to change. Overnight (add \$20)

Please select your method of payment. Check/Money Order American Express Visa MasterCard Discover

Credit Card Number

Expiration Date

/

Total Payment Enclosed \$ _____

Please do not include cash.

Signature _____

Date _____

PLEASE MAIL COMPLETED ORDER FORM, PRESCRIPTION(S) AND PAYMENT TO: P.O. Box 746000, Cincinnati, OH 45274-6000.

If you have questions, please contact Customer Service at 1 (800) 962-8192 or TTY/TDD 1 (800) 221-6915,

Monday through Friday 8:00 a.m. to 11:00 p.m., and Saturday 8:00 a.m. to 7:00 p.m., Eastern Time.

Our Interactive Voice Response (IVR) is now available 24 hours a day, 7 days a week.

Please continue on other side →

Part 2: Confidential Patient Profile

Fill in the appropriate box(es) below for each member of the family that is covered.

	Member	Spouse	Dependent	Dependent	Dependent
Last Name <i>(if different from cardholder name)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Middle Initial	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth <i>(mm/dd/yyyy)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex <i>(M–Male, F–Female)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Allergies to Medications: Check the appropriate box(es) where allergies to medications exist.

Penicillin (31)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine (97)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa (40)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin (4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <i>(Please list all)</i>					
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History: Check the appropriate box(es) for medical conditions diagnosed by a practitioner.

Diabetes (DIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure (HBP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition (HRT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid (THY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma (EYEGLA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers (GSTULC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (MNM CVSNO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis (BNECPR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression (CNSDEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (ART)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Conditions <i>(Please list all)</i>					
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If additional space is needed, please attach a separate sheet indicating patient name, date of birth, sex, and appropriate allergies to medications and medical history.

Please list cardholder name and any medications taken regularly, including over-the-counter drugs, or any additional comments you might have.
