RX ADVANTAGE: EMPLOYEE PRESCRIPTION DRUG PLAN

EMPLOYEE ENROLLMENT FORM

** PLEASE COMPLETE FORM BEFORE COMING TO APPOINTMENT. BRING A COPY OF CURRENT LAB REPORT FROM PRIMARY CARE PROVIDER (PCP) OR YOUR MOST RECENT BIOMETRIC SCREENING FROM REGIONAL ONE HEALTH.					
EMPLOYEE					
NAME: EMPLOYEE SSN:					
INSURANCE ID NO.:	DATE OF BIR	ſH:		PHONE:	
CURRENT ADDRESS:					
CITY:	STATE:		ZIP	CODE:	
	ЕМР	LOYEE - PRIMARY	CARE INFORMATIC	DN	
PRIMARY CARE PROVIDER:					
ADDRESS:				LAS	T VISIT: MONTH: YR
PHONE:	E-MAIL:			FAX	<:
PROVIDER/SPECIALIST:				LAS	T VISIT: MONTH: YR
		MEDICATIO			
IF YOU ARE CURRENTLY BEING SEEN BY AN OUTPATIENT CENTER, DO THEY WRITE YO	IY PHYSICI UR PRESCR	AN OR MEDICAL PRO	NO	NAL	ONE HEALTH, PRIMARY CLINIC OR
MEDICATION ALLERGIES:					
PROVIDER/SPECIALISIT:					
CURRENT MEDICATIONS:	DOSE	EDI			
MEDICATION	DOSE FREQUENCY		PROVIDER		
				-	
				-	
				-	

SIGNATURES				
THE INFORMATION PROVIDED INDICATES THAT ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.				
EMPLOYEE SIGNATURE:	Date:			
PHARMACY SIGNATURE:	Date:			



RX ADVANTAGE: EMPLOYEE PRESCRIPTION DRUG PLAN

SPOUSE ENROLLMENT FORM

** <u>PLEASE COMPLETE FORM BEFORM</u> <u>PROVIDER (PCP).</u>	E COMING	TO APPOINT	MENT. B	RING A COPY OF	CURRENT LAB REPORT FROM PRIMARY CARE	
SPOUSE						
NAME:				SSN		
DATE OF BIRTH:			PHONE			
CURRENT ADDRESS:						
CITY:	CITY: STATE:			ZIP CODE:		
	EN	IPLOYEE - PI	RIMARY	CARE INFORMATI	DN	
PRIMARY CARE PROVIDER:						
ADDRESS:					LAST VISIT: MONTH: YR	
PHONE:	E-MAI	L:			FAX:	
PROVIDER/SPECIALIST:					LAST VISIT: MONTH: YR	
		MED		HISTORY	•	
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MEDICATION ALLERGIES:						
PROVIDER/SPECIALISIT:						
CURRENT MEDICATIONS:						
MEDICATION	DOSE	DOSE FREQUENCY		QUENCY	PROVIDER	

SIGNATURES					
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EMPLOYEE SIGNATURE:	Date:				
PHARMACY SIGNATURE:	Date:				



DEPENDENTENCE	RX AD\	/ANTAGI	E: EMPLO	DYEE	PRESCRIPTI	ON DRUG PLAN			
DATE OF BIRTH: PHONE: CURRENT ADDRESS: STATE: ZIP CODE: CITY: STATE: ZIP CODE: PRIMARY CARE PROVIDER: ADDRESS: PHONE: ADDRESS: PHONE: PHONE: ADRESS: PHONE: PHONE: <tr< th=""><th colspan="7">DEPENDENT ENROLLMENT FORM</th></tr<>	DEPENDENT ENROLLMENT FORM								
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PHARMACY SIGNATURE:	Date:				

