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 BIRTH:**	**PHONE:**
CURRENT ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**

EMPLOYEE - PRIMARY CARE INFORMATION

PRIMARY CARE PROVIDER:		
ADDRESS:		LAST VISIT: MONTH: _____ YR _____
PHONE:	**E-MAIL:**	**FAX:**
PROVIDER/SPECIALIST:		LAST VISIT: MONTH: _____ YR _____

MEDICATION HISTORY

IF YOU ARE CURRENTLY BEING SEEN BY ANY PHYSICIAN OR MEDICAL PROVIDER AT ANY REGIONAL ONE HEALTH, PRIMARY CLINIC OR OUTPATIENT CENTER, DO THEY WRITE YOUR PRESCRIPTIONS? YES ☐ NO ☐

MEDICATION ALLERGIES:

PROVIDER/SPECIALISIT:

CURRENT MEDICATIONS:

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:

Regional One Health

RX ADVANTAGE: EMPLOYEE PRESCRIPTION DRUG PLAN

SPOUSE ENROLLMENT FORM

**** PLEASE COMPLETE FORM BEFORE COMING TO APPOINTMENT. BRING A COPY OF CURRENT LAB REPORT FROM PRIMARY CARE PROVIDER (PCP).**

SPOUSE

NAME:	**SSN**	
DATE OF BIRTH:	**PHONE:**	
CURRENT ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**

EMPLOYEE - PRIMARY CARE INFORMATION

PRIMARY CARE PROVIDER:		
ADDRESS:		LAST VISIT: MONTH: _____ YR _____
PHONE:	**E-MAIL:**	**FAX:**
PROVIDER/SPECIALIST:		LAST VISIT: MONTH: _____ YR _____

MEDICATION HISTORY

IF YOU ARE CURRENTLY BEING SEEN BY ANY PHYSICIAN OR MEDICAL PROVIDER AT ANY REGIONAL ONE HEALTH, PRIMARY CLINIC OR OUTPATIENT CENTER, DO THEY WRITE YOUR PRESCRIPTIONS? YES ☐ NO ☐

MEDICATION ALLERGIES:

PROVIDER/SPECIALISIT:

CURRENT MEDICATIONS:

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:

Regional One Health

RX ADVANTAGE: EMPLOYEE PRESCRIPTION DRUG PLAN

DEPENDENT ENROLLMENT FORM

NAME:	**SSN**	
DATE OF BIRTH:	**PHONE:**	
CURRENT ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**

EMPLOYEE - PRIMARY CARE INFORMATION

PRIMARY CARE PROVIDER:		
ADDRESS:		LAST VISIT: MONTH: _____ YR _____
PHONE:	**E-MAIL:**	**FAX:**
PROVIDER/SPECIALIST:		LAST VISIT: MONTH: _____ YR _____

MEDICATION HISTORY

IF YOU ARE CURRENTLY BEING SEEN BY ANY PHYSICIAN OR MEDICAL PROVIDER AT ANY REGIONAL ONE HEALTH, PRIMARY CLINIC OR OUTPATIENT CENTER, DO THEY WRITE YOUR PRESCRIPTIONS? YES ☐ NO ☐

MEDICATION ALLERGIES:

PROVIDER/SPECIALISIT:

CURRENT MEDICATIONS:

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: