Universal Enrollment Form

Phone: (888) 666 4992
Fax: (615) 259 7601

Vanderbilt Health Pharmacy Group

Patient Information

Patient Name: ____________ DOB: ____________
SSN: ____________ Phone: ____________ Sex: ☐ Male ☐ Female
Address: ____________ Apt/Suite: ____________
City: ____________ State: ____________ Zip: ____________
Caregiver: ____________ Relation: ____________ Phone: ____________
Allergies: ☐ NKDA ☐ Other: ____________

Prescriber Information

Prescriber: ____________ Contact: ____________ Phone: ____________
Address: ____________ Fax: ____________
Apt/Suite: ____________ City: ____________ State: ____________ Zip: ____________
NPI #: DEA #:

Prescription Benefits Information

Plan Name: ____________ ID #: ____________
Group #: ____________ RxBIN: ____________ RxPCN: ____________

Please fax a copy of the patient's insurance card(s)

Clinical Assessment

☐ Patient is New to Therapy ☐ Patient is Restarting Therapy ☐ Patient is Currently on Therapy Start Date: ____________
Primary Diagnosis Code & Condition (ICD-10): ____________ Date of Diagnosis: ____________
Other Diagnosis/Conditions: ____________

Current Weight: ____________ ☐ lb ☐ kg Date: ____________ Current Height: ____________ ☐ in ☐ cm Date: ____________
☐ Other Therapies Tried & Failed (Please list): ____________
List Dates of Tried & Failed Therapies: ____________
Date Needed: ____________ Shipping to: ☐ Patient's Home ☐ Provider's Office

Prescription Information

Medication	Strength	Formulation	Directions	Quantity	Refills

If a brand name product is desired, the prescriber must handwrite "brand name medically necessary," "dispense as written," or "no generic" on the prescription. ____________

Stamp signature not allowed, physician signature required

Prescriber's Signature: ____________ **Date**: ____________

By signing above, I authorize Vanderbilt Health Pharmacy Group and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I understand that I can revoke this designation at any time by providing written notice to Vanderbilt Health Pharmacy Group.

Important: This information is intended only for the use of the individual or entity named above. It may contain information which may be proprietary and confidential. It also may contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender immediately and arrange for the return or destruction of these documents.