



CuraScript Pharmacy Enrollment Form

Fax: 888.773.7386

Phone: 888.484.6931

Last Name	First Name	Home Phone Number ()	Work Phone Number ()	Today's Date	Date Needed
Parent / Guardian				Physician's Name (please print)	Hospital / Clinic
Home Address	City	State	Zip	Address	City State Zip
Shipping Address (If different from home address)				Phone Number ()	Fax Number ()
Social Security Number		Date of Birth		Office Contact	

Allergies:	Patient's Weight:
Special Instructions (Non-English Speaking Patients, etc.)	

Primary Insurance Company	Phone ()	Name of Insured / SSN	Employer Name / ID Number	Group Number
Secondary / Supplemental Insurance Company	Phone ()	Name of Insured / SSN	Employer Name / ID Number	Group Number

Medication: _____ Direction for Use: _____ Quantity: _____ Refill x _____ month(s)	Medication: _____ Direction for Use: _____ Quantity: _____ Refill x _____ month(s)	Medication: _____ Direction for Use: _____ Quantity: _____ Refill x _____ month(s)
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Delivery Instructions: Home Work Other _____

Physician's Signature: _____ **UPIN # / DEA** _____

Statement of Medical Necessity

Primary Diagnosis: _____ ICD 9 Code _____

Medical History: _____

Estimated Start of Therapy: _____

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS