Phone: (844) 431 – 7277

Fax: (844) 432 - 7277

Specialty Pharmacy Services Enrollment Form

New York Prescribers, please submit an electronic prescription together with the Enrollment Form

HIV

For pharmacy locations, please scan QR code.

PATIENT INFORMATION

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: M F	Weight:	Height:	Diabetic: Y N
Address:	City:	State:	Zip:	Allergies:
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? Y N

PRESCRIBER INFORMATION

Prescriber Name: MD   DO   NP   PA   NPI:

Supervising Physician, if applicable:

Address: City:

State: Zip: Phone: Fax:

INSURANCE INFORMATION ı PLEASE SEND COPY OF INSURANCE CARD

Primary Insurance: Policy ID: Group #:

Policyholder Name: Policyholder DOB: BIN: PCN:

CLINICAL INFORMATION ı PLEASE SEND COPY OF PROGRESS NOTES AND LAB REPORTS SUPPORTING DIAGNOSIS

ICD-10 Diagnosis Code:	Human Immunodeficiency Virus (HIV) Disease (B20)	Encounter for HIV Pre-Exposure Prophylaxis (Z29.81)	Chronic Viral Hepatitis C (B18.2)
Cachexia (R64)	Chronic Viral Hepatitis B with Delta Agent (B18.0)	Chronic Viral Hepatitis B without Delta Agent (B18.1)	Other: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Quantity	Refills

AUTHORIZATION

By signing this form and utilizing our services, you are authorizing Price Chopper Specialty to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: Date: Prescriber Signature: Date:

Substitution Permitted: Issued: Dispense as Written

Interchange is mandated unless the practitioner indicates 'Dispense as Written' or 'No Substitution' in accordance with the law.