Homescripts™
An envolve Solution

envolve™
Pharmacy Solutions

Member Enrollment Form

PERSONAL INFORMATION

Name: _____ Date of Birth (mm/dd/yy): _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email Address:* _____

Emergency Contact: _____ Phone: _____

Relationship to Member: _____ ☐ Authorized to disclose information

Allergies: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Other: _____

Health Condition(s): ☐ Thyroid ☐ Diabetes ☐ Arthritis ☐ Heart Conditions ☐ High Blood Pressure ☐ Depression

☐ Asthma ☐ High Cholesterol ☐ Other: _____

**By providing your email address, you consent to receive email notifications regarding your prescription benefits, as well as other information on behalf of Homescripts and Envolve Pharmacy Solutions. You may opt out of this email service at any time by contacting us or following the opt-out instructions included in each email you receive.*

HEALTHCARE PRACTITIONER INFORMATION

Name (Printed): _____ Phone: _____ Fax: _____

PRESCRIPTION INSURANCE INFORMATION

Policyholder (if different than above): _____

Relationship to Member: _____

Cardholder ID #: _____ Rx Group: _____

Rx BIN #: _____ PCN/Plan Code: _____

Insurance Name: _____ Insurance Phone: _____

PAYMENT INFORMATION

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex Use this card for future orders? ☐ Yes ☐ No

Credit Card #: _____ Expiration Date: ____/____ Is this an FSA card? ☐ Yes ☐ No

Cardholder Name: _____ Cardholder Signature: _____

(Turn over to complete)

2019

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MEDICATION HISTORY

Please list all prescription and over-the-counter medications you are currently taking.

Medication Name	Strength

Medication Name	Strength

PRESCRIPTION INFORMATION

Please allow 7-10 business days to receive your medication orders.

Notify your doctor that you are now using Homescripts Pharmacy and to ePrescribe your prescriptions.

Homescripts Pharmacy

500 Kirts Blvd., Suite 300
Troy, MI 48084

Phone: 1.888.239.7690 **TTY:** Please dial 711 **Fax:** 877.396.5970

customerservice@homescripts.com

US law prohibits **patients** from emailing or faxing prescriptions directly to the pharmacy.

SPECIAL INSTRUCTIONS

Please include any special instructions regarding your order:

_____

_____

PLEASE READ, SIGN, & DATE

I certify that the information provided on this form is correct and authorize the release of all information to Homescripts, I authorize my provider to send my prescription(s) to Homescripts, and to consult with a Homescripts pharmacist regarding any medication related concerns. I AUTHORIZE HOMESCRIPTS PHARMACY TO SUBSTITUTE ANY FDA-APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PROVIDER'S ORDERS AND MY BENEFIT PLAN.

Name (Printed): _____

Signature of Member or Legal Representative: _____ Date: _____

☐ Yes, I would like to receive easy-open, non-safety caps. Initials: _____

Please email the completed, saved form to customerservice@homescripts.com or fax to 877.396.5970.