AccuPac™ Signup Sheet

Pharmacy 800-727-5823
FAX 412-586-5351

Start Date

Ship To: ☐ Patient ☐ Office ☐ **Other**

1. Patient Information: Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. #_____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Prescription Information:

Prescription #1

Medication	Dosage	Quantity	Directions	Refills	Time to Take

Prescription #2

Medication	Dosage	Quantity	Directions	Refills	Time to Take

Prescription #3

Medication	Dosage	Quantity	Directions	Refills	Time to Take

Prescription #4

Medication	Dosage	Quantity	Directions	Refills	Time to Take

Prescription #5

Medication	Dosage	Quantity	Directions	Refills	Time to Take

Prescription #6

Medication	Dosage	Quantity	Directions	Refills	Time to Take

Prescription #7

Medication	Dosage	Quantity	Directions	Refills	Time to Take

3. Prescriber and Shipping Information:

Prescriber (print):_____ **Office Contact:** _____

Preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:**_____

Office Address: _____

Phone: _____ **fax:**_____ **NPI:**_____ **DEA:**_____

Prescriber's Signature: _____ **Date:**_____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process**. (NO STAMPS)**

4. Patient Support Programs (optional): Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ **Date:**_____

5. Insurance Information: Please fax a copy of the insurance card (front & back)