



**CuraScript Pharmacy**

**Prescription Enrollment Form**

**Fax: 888.773.7386**

**Phone: 888.773.7376**

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
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: _____	Medication: _____	Medication: _____
Direction of Use: _____	Direction of Use: _____	Direction of Use: _____
Quantity: _____ Refill x _____ month(s)	Quantity: _____ Refill x _____ month(s)	Quantity: _____ Refill x _____ month(s)

**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**