Indiana University Health

IU Health Advanced Therapies Pharmacy
355 W. 16th St. Suite 1600 GH 1074
Indianapolis, IN 46202-2278
Phone: 317.963.7100 **Toll Free:** 844.678.7100
Fax: 317.963.7119

New Patient Enrollment

Need to send us a paper prescription? Please print this form and mail to us along with your **original** paper prescriptions. We will process your order and deliver to your address free of charge. Use this form if you are a new IU Health Advanced Therapies Pharmacy Mail Order patient. Existing patients complete the Patient Information Update Form instead.

Please complete all fields for up to three family members, then print and mail with **original** prescriptions to the address above.

Section 1: Patient Information & Allergies

Patient 1 First Name _____ Patient's Last Name _____ Patient's Date of Birth _____ ☐ Male ☐ Female ☐ Cardholder ☐ Spouse ☐ Dependent

☐ No Known Allergies _____
List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 2 First Name _____ Patient's Last Name _____ Patient's Date of Birth _____ ☐ Male ☐ Female ☐ Spouse ☐ Dependent

☐ No Known Allergies _____
List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 3 First Name _____ Patient's Last Name _____ Patient's Date of Birth _____ ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____
List any drug allergies and any reaction you had. Include over-the-counter medications.

Section 2: Delivery Information

Street Address _____ Apartment/Ste. _____ City _____ State _____ Zip Code _____

Daytime Phone Number _____ Evening Phone Number _____ Email Address _____

Preferred Contact Method: _____

***Please note that the pharmacy will not ship any medications if they are unable to contact you.**

Section 3: Prescription Insurance Information

Provide the information below as found on your prescription benefit card.

Name of Insurance or Health Plan _____ Identification Number _____ Group Number _____ Bin _____ PCN _____

Cardholder's First Name _____ Cardholder's Last Name _____ MI _____

Name of Secondary Insurance or Health Plan _____ Identification Number _____ Group Number _____ Bin _____ PCN _____

Cardholder's First Name _____ Cardholder's Last Name _____ MI _____

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Section 4: Payment Information

CREDIT CARD: For your safety we do not collect credit card numbers on this form. If you would like to pay by credit card please indicate below. A member of our customer service team will contact you to collect your credit card information. Orders will not ship until a form of payment is on file. Credit card will be used for the entire co-pay and any future orders until a new form of payment is specified. **By signing in the Patient Signature for Credit Card, you are authorizing IU Health Advanced Therapies Pharmacy to charge any balances, deductibles or co-pays due.**

We accept Master Card, Visa, FSA and HSA cards.

☐ Please contact me to set up my credit card. Best contact number: ( ) ____ - _____ Patient Signature for Credit Card: _____

IU HEALTH EMPLOYEE PAYROLL DEDUCTION: By signing, I certify that I am actively employed at IU Health. I authorize deduction from my paycheck the sum of the co-pay incurred from use at an IU Health Pharmacy.

☐ IU Health Employee Payroll Deduction Employee ID _____ Employee Signature _____

☐ Check/Money Order enclosed Amount: $_____

Please note that you will be contact if your prescription costs more than $100.00 or an increase in copay amount $50.00

Section 5: Prescription Information - New or Transfer prescriptions

New or transfer prescriptions? If you have additional prescriptions you would like to transfer to IU Health Advanced Therapies Pharmacy, please complete the sections below. We will contact your doctor or current pharmacy and transfer your prescriptions. *It's as easy as that!*

Patient Name _____ Patient's Date of Birth _____

☐ I want a 30 Day Supply
☐ I want a 90 Day Supply
☐ Do not contact my doctor.

_____ _____
Medication Name / Prescription Number Doctor or Pharmacy Name / Phone

☐ I want a 30 Day Supply
☐ I want a 90 Day Supply
☐ Do not contact my doctor.

_____ _____
Medication Name / Prescription Number Doctor or Pharmacy Name / Phone

Patient Name _____ Patient's Date of Birth _____

☐ I want a 30 Day Supply
☐ I want a 90 Day Supply
☐ Do not contact my doctor.

_____ _____
Medication Name / Prescription Number Doctor or Pharmacy Name / Phone

☐ I want a 30 Day Supply
☐ I want a 90 Day Supply
☐ Do not contact my doctor.

_____ _____
Medication Name / Prescription Number Doctor or Pharmacy Name / Phone

I authorize IU Health Advanced Therapies Pharmacy to mail prescription medicine directly to the location I have specified. I authorize IU Health Advanced Therapies Pharmacy to leave any supply or product order in a designated area if I am not home to accept the delivery. I certify that all the information on this form is correct. I permit IU Health Advanced Therapies Pharmacy to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Authorized Signature: _____ Date: _____