

CAREMARK ENROLLMENT FORM

Section 1 should be completed by the patient. Section 2 should be completed by the physician and staff.
Section 3 provides the fax number to send the completed form to.

CAREMARKCONNECT®

TEL (800) 237-2767

FAX (800) 323-2445

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PATIENT INFORMATION

Last Name	First Name	Middle Initial	
Street Address	City	State	Zip Code
Day Telephone (+Area Code)	Night Telephone (+Area Code)	<input type="checkbox"/> M <input type="checkbox"/> F	
Date of Birth	Social Security Number	Sex (✓One)	

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Cardholder Name & Social Security Number (If Not Patient)	Cardholder Name & Social Security Number (If Not Patient)
Group/Policy Number	Group/Policy Number
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)
Employer	Medicaid Number

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law. In signing below, you indicate and acknowledge that the information you provided above is true and correct.

Patient Signature: _____ Date: _____

CAREMARK Thank you for choosing Caremark!
It all starts with care™

PHC1934-042403BL

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PHYSICIAN INFORMATION

Prescriber's Name	Hospital/Clinic	Office Contact
Address	City/State/Zip	Telephone Number (+Area Code)
Prescriber's License Number	DEA Number	Fax Number (+Area Code)
Supervising Physician's Name (If Required for Mid-Level Practitioner)	License Number	

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)

Date Of Diagnosis

INJECTION TRAINING

Injection Training will be/has been conducted by the physician's office? Y N Date: _____
First dose of medication will be/has been administered at physician's office? Y N Date: _____
Caremark to refer/coordinate injection training? Y N

Rx

Patient Weight: _____ kg. OR _____ lbs.

Ancillary supplies as needed for injection.

Enroll patient in manufacturer support program

Other Prescriber's Notes:

Refill: 12 months Refill _____ times
 Dispense As Written Substitution Allowed

Prescriber's Signature: _____

Physician's Signature (If required for Medical Necessity)

Date: *Unless otherwise indicated, date used will be date of fax transmission.*

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FAX COMPLETED FORM TO CAREMARKCONNECT® AT 1 (800) 323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.