BOCA PHARMACY

Enrollment Form

Sign and fax this for m to 718.874.1378
Questions 844.340.2622

Clinic/Patient to complete Patient to complete

PATIENT INFORMATION

First Name:	MI:	Last Name:
Date of Birth:	Gender: M F TG	Social Security Number:
Address:		Apt. #
City:	State:	Zip:
Email:	Home Phone:	Mobile Phone:
Principal Language Spoken:	MAR Needed	Allergies:

SHIPPING INFORMATION

Same as Home Other (complete fields below)

Name:		
Address:	City:	
State:	Zip:	Phone:
Special Instructions:		

CLINIC INFORMATION

Clinic Name:	
Clinic Contact:	
Office Phone:	Mobile Phone:
Email:	

DESIGNATED CONTACT PREFERENCE

Designated Patient Clinic Contact (listed above)
Case Manager Other (complete fields below)

Contact Name:	
Phone:	Email:

PACKAGING

Right-On-Time Pack (multi-med): Weekly Monthly

Vials Other "RIGHT-ON-TIME PACK" AND "OTHER" ARE NOT CHILD-PROOF PACKAGING. PATIENT INITIALS:

PHYSICIAN INFORMATION

Physician 1:	
Clinic/Affiliation Name:	
Phone:	Fax:
Physician 2:	
Clinic/Affiliation Name:	
Phone:	Fax:

INSURANCE INFORMATION

Fax a copy of the front and back of prescription insurance card(s) or fill in the information below.

Insurance 1:	Phone:
ID #:	Group #:
BIN #:	PCN #:
Insurance 2:	Phone:
ID #:	Group #:
BIN #:	PCN #:

CURRENT PHARMACY

Pharmacy Name:	
Phone:	

MEDICATION NAME	STRENGTH	PRESCRIBING PHYSICIAN	ICD CODE/DIAGNOSIS	NEXT FILL DATE	BOCA TO FILL
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N

PATIENT AUTHORIZATION

BOCA Pharmacy has been chosen by your provider to provide pharmacy services to its patients. You have a choice of pharmacies.
Please check the box below, sign and date if you would like BOCA to fill your prescriptions.

- ☐ I choose BOCA to fill my prescriptions
- ☐ I authorize BOCA to automatically refill my prescriptions
- ☐ I choose to participate in BOCA's coordinated refill program ('Medsync")

Patient/Legal Guardian Signature:	Date: