Intermountain Home Delivery Pharmacy

ENROLLMENT FORM

Intermountain Home Delivery Pharmacy is a great option to get the medications you need delivered right to your door. In order to get started, we need to get some information about you so that we can provide you the best service and care possible. Please complete the form below to the best of your knowledge. If you have any questions, don't hesitate to contact us at (801) 501-6910, or (855) 779-3960.

FOR NEW HOME DELIVERY PRESCRIPTIONS, PLEASE FOLLOW THESE STEPS

1. If you need to start your medication right away, please have your physician complete two prescriptions.
2. Fill one prescription at a local pharmacy of your choice and submit the other prescription to the Intermountain Home Delivery Pharmacy. Encourage your physician to write for the maximum day supply covered by your benefit plan.
3. Complete the information below for you and any family members who will utilize the Intermountain Home Delivery Pharmacy to fill prescriptions.
4. Mail this information and the original prescription(s) to:

   Intermountain Home Delivery Pharmacy
   7268 So. Bingham Junction Blvd., Suite B1
   Midvale, Utah 84047
5. Expect delivery of your order within 5 business days from the date your order is postmarked.

MEMBER INFORMATION

Name (Last, First, MI): _____

Date of birth: _____ Sex (M/F): _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Email address (Optional): _____

Medication Allergies (List all): _____

Prescription Insurance (ie. SelectHealth, Express Scripts): _____

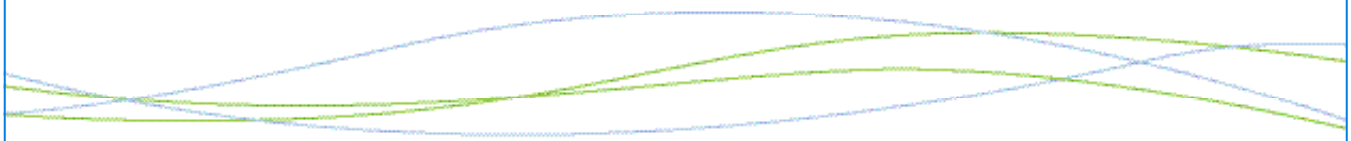
Cardholder ID: _____ BIN #: _____

PROVIDER INFORMATION

Doctor name (Last, First, MI):_____ Phone: _____

Doctor name (Last, First, MI):_____ Phone: _____

Doctor name (Last, First, MI):_____ Phone: _____



DEPENDENT #1 INFORMATION

(Fill out this section for each member of your household that will use Intermountain Home Delivery Pharmacy)

Name (Last, First, MI): _____

Relationship to member (ie. spouse, child): _____

Date of birth: _____ Sex (M/F): _____ Phone: _____

Medication Allergies (List all): _____

DEPENDENT #1 PROVIDER INFORMATION

Doctor name (Last, First, MI):_____ Phone: _____

Doctor name (Last, First, MI):_____ Phone: _____

DEPENDENT #2 INFORMATION

(Fill out this section for each member of your household that will use Intermountain Home Delivery Pharmacy)

Name (Last, First, MI): _____

Relationship to member (ie. spouse, child): _____

Date of birth: _____ Sex (M/F): _____ Phone: _____

Medication Allergies (List all): _____

DEPENDENT #2 PROVIDER INFORMATION

Doctor name (Last, First, MI):_____ Phone: _____

Doctor name (Last, First, MI):_____ Phone: _____

PLEASE READ AND SIGN

By signing below, I acknowledge the following:

- The information that I provided on this form is correct to the best of my knowledge
- That Intermountain Home Delivery Pharmacy will substitute generic formulations of medication unless my prescriber indicates otherwise
- That I may contact Intermountain Home Delivery Pharmacy to speak with a pharmacist about my medications

Signature: _____ Date: _____

Intermountain Pharmacy Services

7268 So. Bingham Junction Blvd., Suite B1 • Midvale, Utah 84047
(801) 501-6910 • (855) 779-3960 • *IntermountainRx.org/HomeDelivery*