

**Patient Insurance Information**

Please Attach to Patient Prescription

Fax to (877) 291-1155

Please attach a copy of insurance card (front and back).

Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

Policyholder's Relationship to Patient \_\_\_\_\_

Policyholder's ID # \_\_\_\_\_

Group # \_\_\_\_\_

**Rx Insurance Drug Card** \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Id # \_\_\_\_\_

Rx Group # \_\_\_\_\_

Rx Bin# \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

Policyholder's Relationship to Patient \_\_\_\_\_

Policyholder's ID # \_\_\_\_\_

Group # \_\_\_\_\_

**Rx Insurance Drug Card** \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Id # \_\_\_\_\_

Rx Group # \_\_\_\_\_

Rx Bin# \_\_\_\_\_