

## Patient Insurance Information

Please Attach to Patient Prescription

Fax to 877.291.1155

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

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

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

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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# \_\_\_\_\_

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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# \_\_\_\_\_