



# AccuPac™ Signup Sheet

Pharmacy 800-727-5823

FAX 412-586-5351

Start Date

Ship To:  Patient  Office  Other

## 1. Patient Information: Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: \_\_\_\_\_ Male / Female DOB: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
First Name Last Name

Address: \_\_\_\_\_  
Street City State Zip

Primary phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

Caregiver: \_\_\_\_\_ Allergies: \_\_\_\_\_

Comorbidities: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## 2. Prescription Information:

### Prescription #1

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

### Prescription #2

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

### Prescription #3

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

### Prescription #4

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

### Prescription #5

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

### Prescription #6

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

### Prescription #7

Medication	Dosage	Quantity	Directions	Refills	Time to Take
_____	_____	_____	_____	_____	_____

## 3. Prescriber and Shipping Information:

Prescriber (print): \_\_\_\_\_ Office Contact: \_\_\_\_\_

Preferred method of contact:  phone  fax  email preferred contact persons email: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone: \_\_\_\_\_ fax: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

## 4. Patient Support Programs (optional): Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 5. Insurance Information: Please fax a copy of the insurance card (front & back)

\*IMPORTANT NOTICE: this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 412-586-5351.. Visit us at [WWW.ACCUSERVPHARMACY.COM](http://WWW.ACCUSERVPHARMACY.COM) for online fillable forms.