Patient Registration Form

P.O. Box 1244 • Winter Park, FL 32790-1244
Toll free: 866-699-8239 • **Fax 407-671-7960**
www.Xubex.com

Complete this form to enroll in Xubex's Discount Mail-Order Pharmacy and Patient Assistance Program. Please note that ***this is not a free prescription program, however there may be little to no out-of-pocket cost.*** Mail or fax the completed form to the address or fax number listed above.

IMPORTANT: Please have your prescribing physician(s) complete and sign the Physician Order Sheet for new prescriptions.

PROGRAM(S) APPLIED FOR		
☐ Discount Drug Program ☐ Co-Pay Assistance Program ☐ Free Trial Medication Program		
PATIENT INFORMATION		
First:	Last:	M.I.:
Address:		
City:	State:	Zip:
Shipping Address: ☐ Same as Above		
Date of Birth:	☐ Male ☐ Female	SSN:
Best Phone:	Alt. Phone:	
Email:	Drivers License #:	
INSURANCE INFORMATION		
Do you want us to bill your insurance? ☐ YES ☐ NO	**Do you have Medicare?** ☐ YES ☐ NO	Medicare ID#:
Prescription Insurance Company:		Phone:
BIN #:	PCN #:	ID #:
Group#	Additional Information:	

DRUG AND FOOD ALLERGIES				
☐ Codeine (32)	☐ Sulfa (87)	☐ Penicillin (70)	☐ Tetracycline (93)	☐ Other (00)
List Other Allergies:				

ADDITIONAL INFORMATION		
If you have or are a Patient Advocate/Case Manager please fill out this section:		
First:	Last:	
Phone:	Fax:	Email:
Organization:	Address:	
Is there anything else that you would like us to know so that we may better serve you?		

FOR OFFICE USE ONLY:		
Patient Code:	Date Received:	By:
☐ No Prescription Attached ☐ No Payment ☐ Incomplete Application ☐ Contact Physician ☐ Bill Ins. ☐ Transfer		

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Affordable Quality Care

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PRESCRIPTION TRANSFER INFORMATION

Please complete this section **only if you are transferring your prescription(s) from your current pharmacy to Xubex**. Your prescriptions must be transferred from you current pharmacy to Xubex in order to participate in the Patient Assistance Program. For faster processing, instead of transferring your prescriptions please have your physician complete the Physician Order Sheet.

New York State Residents: Our pharmacy staff can transfer one refill from your home pharmacy. If more than one refill is required, the prescribing clinician must authorize the transfer. **PLEASE NOTE: This form cannot be used to transfer controlled medications.

You authorize Xubex to transfer the medications listed below from your current pharmacy to Xubex ☐ YES ☐ NO

Current Pharmacy:	Pharmacy Phone:	Pharmacy Fax:

MEDICATIONS TO BE TRANSFERRED

DRUG NAME	STRENGTH	Rx NUMBER

☐ **Check here if you authorize pharmacist to substitute for generic medication**

METHOD OF PAYMENT

****Please include price of your medication(s) plus the cost for the selected shipping option in your payment.****

Payment Type: ☐ Check ☐ Money Order ☐ Credit/Debit Card	☐ AMEX ☐ VISA ☐MASTERCARD ☐ DISCOVER

Cardholder Name:		
Cardholder Address:		☐ Same as above
City:	State:	Zip:
Card Number:	Expiration Date: _____/_____	CVV Code:
$ Amt. To Be Charged:	Charge Me For A: ☐30 Day Supply ☐60 Day Supply ☐90 Day Supply ☐_____ Day Supply	

SHIPPING OPTIONS

Please select one:	☐ Standard Shipping $3.85	☐ 2-3 Day Shipping $25.00	☐ Overnight Shipping $45.00

☐ Check if you would like to add the Signature Required Option to your shipping for $3.00

My signature below authorizes Xubex to administer the following:

1. Use any information that I provide in this registration form to enroll in the Xubex Patient Assistance and Mail Order program.
2. Receive and keep records of all prescriptions for the medications I receive under the program.
3. Contact my doctor(s), health care provider(s), and/or pharmacist about my registration for the program, and disclose to the information contained in this registration form.
4. Request information from my insurer(s), physician(s), health care provider(s), and/or pharmacist about the prescribed medications I receive or will receive while enrolled in the program and about my medical condition. By signing below, I authorize my insurer(s), physician(s), health care provider(s), and/or pharmacist to release information about my prescribed medications and medical condition that is requested by Xubex.
5. Contact my insurer(s) and other potential funding sources on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in this registration form or information about my prescribed medications and medical condition that has been provided by my physician(s), health care provider(s), and/or pharmacist.
6. I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I am enrolled and participate in the program and for a period of three (3) years after my participation in the program ends. Furthermore, I certify that the information provided on this registration form is complete and accurate to the best of my knowledge and agree to notify Xubex of any change in my insurance eligibility.
7. By submitting this application, I confirm that I have read, understand, and agree to the Xubex privacy policy posted at: http://www.xubex.com/privacypolicy.aspx

PATIENT SIGNATURE:	**DATE:**

Physician Order Sheet Rx

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For faster processing: If you already have written prescriptions from your physician, you do not need the Physician Order Sheet. Please attach them to your completed registration form for submission. If not, this form is to be filled out by the prescribing physician(s) and will serve as prescription order(s). Please make additional copies for each separate prescribing physician and /or if additional copies are needed.

PATIENT INFORMATION			
First:	Last:	M.I.:	
Date of Birth:	SSN:	☐Male ☐ Female	
Best Phone:	Alt. Phone:	Email:	
Address:	City:	State:	Zip:

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

☑ PRESCRIPTION

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

PRESCRIBER SIGNATURE REQUIRED	
PHYSICIAN SIGNATURE:	**Date**:

****This prescription form is not valid for use for Class II Controlled Substances.**
The Physician Order Sheet is for use at Xubex only. **