



UCHealthRX:MailOrder Pharmacy Enrollment Form

Please complete one form for each family member enrolled in UCHealth Preferred medical coverage.

Associate Information

Name as it appears on your UCHealth Preferred card	Last name	First name	M.I.	ID# from your card	2-digit number next to your name on card
Home address (Street, Apt. Number, City, State, Zip)			Daytime phone	Evening phone	
Work e-mail		Home e-mail			

Payroll		Payment information	
<input type="checkbox"/> University Hospital	<input type="checkbox"/> UC Health Business Center	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard
<input type="checkbox"/> West Chester Hospital	<input type="checkbox"/> UCP/UCPC	Name on credit card _____	
<input type="checkbox"/> The Drake Center		Number on credit card _____	
		Expiration date _____	

Member Information (Person for whom medications are being ordered)

Last name, first, M.I.	2-digit # next to name on card	Date of birth
Shipping address (If different from home address above)		Sex <input type="checkbox"/> F <input type="checkbox"/> M

Member's Current Health Conditions

<input type="checkbox"/> Blood clotting disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate disease	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Ulcers
	<input type="checkbox"/> Epilepsy (Seizures)	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Allergies _____					
<input type="checkbox"/> Other _____					

Member's Current Medications (Required for medication interaction screening)

Prescription medications being taken	Non-prescription medications being taken	Herbal medications being taken

Your Authorization

In connection with the benefits I am requesting, I may be asked to consent to the use or disclosure of my medical information for purposes of my treatment, for payment of my benefits or for other administrative purposes. I may also be asked to specifically authorize the disclosure of my medical information for other purposes. I am aware that providing false information or submitting a false or deceptive claim is considered the crime of insurance fraud and certify that information provided on this form is accurate to the best of my knowledge.

Signature Date

Return this form by fax to UCHealthRX:MailOrder, (513) 584-5270 or mail the form directly to UCHealthRX:MailOrder, The University Hospital Pharmacy, ML – 739B, 234 Goodman Street, Cincinnati, OH 45219.

Enrollment Questions? Call UCHealthRX at (513) 585-6201