Lehigh Valley Health Network
Your health deserves a partner.

PATIENT ENROLLMENT FORM

Health Spectrum Pharmacy Services

Please indicate which LVHN campus you are employed at:

- ☐ Cedar Crest
- ☐ Muhlenberg
- ☐ 17th Street
- ☐ Pocono
- ☐ Hazleton
- ☐ Schuylkill
- ☐ Coordinated Health
- ☐ Other (ExpressCare, offsite LVPG office, etc): _____

Section 1: Patient Information & Allergies

If additional space is needed, please continue on a second form.

Patient 1 _____ First Name _____ Last Name ___/___/___ Date of Birth ☐ Male ☐ Female ☒ Cardholder

☐ No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 2 _____ First Name _____ Last Name ___/___/___ Date of Birth ☐ Male ☐ Female ☐ Spouse ☐ Dependent

☐ No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 3 _____ First Name _____ Last Name ___/___/___ Date of Birth ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 4 _____ First Name _____ Last Name ___/___/___ Date of Birth ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 5 _____ First Name _____ Last Name ___/___/___ Date of Birth ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 6 _____ First Name _____ Last Name ___/___/___ Date of Birth ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Please complete the “Delivery & Contact Information” and “Payment Information” sections located on page 2.

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Section 2: Delivery & Contact Information

Primary Address: (Patient 1's name will be utilized),

Street Address	Apartment/Ste.	City	PA State	Zip Code

☐ Cell ☐ Home ☐ Work — Daytime Phone Number

☐ Cell ☐ Home ☐ Work — Evening Phone Number

Email Address

Secondary Address: (college, 2nd home, caretaker, etc…) **Dates:** / / **to** / /

Street Address	Apartment/Ste.	City	PA State	Zip Code

☐ Cell ☐ Home ☐ Work — Daytime Phone Number

☐ Cell ☐ Home ☐ Work — Evening Phone Number

List Patient(s) At This Address When In Use

Tertiary Address: (college, 2nd home, caretaker, etc…) **Dates:** / / **to** / /

Street Address	Apartment/Ste.	City	PA State	Zip Code

☐ Cell ☐ Home ☐ Work — Daytime Phone Number

☐ Cell ☐ Home ☐ Work — Evening Phone Number

List Patient(s) At This Address When In Use

Section 3: Payment Information

This payment information will apply to all patients listed in Section 1

Please provide your regular credit card info and, if enrolled, your healthcare flexible spending (FSA) credit card information

☐ **Check here to have a Health Spectrum staff member contact you for your credit card information.**

Credit Card Number | / Expiration Date | Name on Card | ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

FSA Card Number (if applicable) | / Expiration Date | Name on Card | ☐ Visa ☐ MasterCard ☒ FSA

By signing, I certify that I am authorizing Health Spectrum Pharmacy Services to charge the credit card(s) listed above and any subsequent cards that are provided for the cost of the prescriptions and any shipping fees that are incurred by utilizing this convenience shipping services. I also certify that I have received, read and understand all of the provisions and guidelines contained on this form and on the accompanying Convenience Shipping Information form. Prescriptions will not ship unless payment is made and are non-returnable.

Name (Please Print) | Signature | / / Date

Please fax completed enrollment form to Health Spectrum Pharmacy - Muhlenberg at (484) 884-2969

Health Spectrum Pharmacy Services

Convenience Shipping Information

Who – available to all Health Spectrum Pharmacy Services customers

What – a home shipping service for prescription refills

When – it starts as soon as we receive your completed enrollment form

Where – stop in to any Health Spectrum Pharmacy Services location to sign up

<u>You will need to provide:</u>

- US Postal Service Address(es)
- Phone Number
- Email Address
- Payment Information—Credit Card and Flexible Spending Account (if applicable)
- Signature—by signing the enrollment form, you are agreeing to be charged your co-pay as well as any applicable shipping fees for all prescriptions you request to have shipped.

Guidelines

Convenience shipping is offered Monday through Friday. Standard shipping for most medications is FREE to all. Overnight shipping for refrigerated medications is available through FedEx, also free of charge. Need a non-refrigerated item sent overnight?—we are able to do this at your request, however you will be responsible for the overnight shipping fee.

Refill requests may be submitted to the pharmacy on-line, by phone, or through our app, MobileRx®. At that time, you must indicate that you would like the refill(s) shipped.

New prescriptions will not be automatically shipped—*why not*?

- There are some cases in which you may need a prescription the same day (ex: antibiotics, pain medication, rescue inhaler, etc).
- Your prescriber may send a prescription to the pharmacy that you decide against – you would be charged for the co-pay.

When your order is processed, you will receive an email containing a tracking number.

By default, shipments will be sent using the name of Patient 1 on the enrollment form to the primary address listed. If an alternate address is used, the first name listed for that location will become the ship-to contact.

You can expect to receive your standard packages in 3-5 business days.

Prescriptions sent to your home are non-returnable.