Homescripts™
An envolve Solution

ambetter of North Carolina Inc.

envolve™ Pharmacy Solutions

Member Enrollment Form

PERSONAL INFORMATION

Name: ______ Date of Birth (mm/dd/yy): ______ Gender: ☐ Male ☐ Female

Address: ______ City: ______ State: ______

Zip Code: ______ Home Phone: ______ Cell Phone: ______

Email Address:* ______

Emergency Contact: ______ Phone: ______

Relationship to Member: ______ ☐ Authorized to disclose information

Allergies: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa Other: ______

Health Condition(s): ☐ Thyroid ☐ Diabetes ☐ Arthritis ☐ Heart Conditions ☐ High Blood Pressure ☐ Depression ☐ Asthma ☐ High Cholesterol Other: ______

**By providing your email address, you consent to receive email notifications regarding your prescription benefits, as well as other information on behalf of Homescripts and Envolve Pharmacy Solutions. You may opt out of this email service at any time by contacting us or following the opt-out instructions included in each email you receive.*

HEALTHCARE PRACTITIONER INFORMATION

Name (Printed): ______ Phone: ______ Fax: ______

PRESCRIPTION INSURANCE INFORMATION

Policyholder (if different than above): ______

Relationship to Member: ______

Cardholder ID #: ______ Rx Group: ______

Rx BIN #: ______ PCN/Plan Code: ______

Insurance Name: ______ Insurance Phone: ______

PAYMENT INFORMATION

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex Use this card for future orders? ☐ Yes ☐ No

Credit Card #: ______ Expiration Date: ____/____ Is this an FSA card? ☐ Yes ☐ No

Cardholder Name: ______ Cardholder Signature: ______

(Turn over to complete)

2019

Toll-free: 1.888.239.7690
TTY: Please dial 711 for phone relay assistance

Customer Service Hours:
M-F 8am - 8pm EST, Sat 10am - 2pm EST

AMB19-NC-C-00136

Homescripts
An envolve Solution

ambetter of North Carolina Inc.

envolve Pharmacy Solutions

Member Enrollment Form

MEDICATION HISTORY

Please list all prescription and over-the-counter medications you are currently taking.

Medication Name	Strength	Medication Name	Strength

PRESCRIPTION INFORMATION

Please allow 7-10 business days to receive your medication orders.

Notify your doctor that you are now using Homescripts Pharmacy and to ePrescribe your prescriptions.

Homescripts Pharmacy

500 Kirts Blvd., Suite 300
Troy, MI 48084

Phone: 1.888.239.7690 **TTY:** Please dial 711 **Fax:** 877.396.5970

customerservice@homescripts.com

US law prohibits **patients** from emailing or faxing prescriptions directly to the pharmacy.

SPECIAL INSTRUCTIONS

Please include any special instructions regarding your order:

____

____

PLEASE READ, SIGN, & DATE

I certify that the information provided on this form is correct and authorize the release of all information to Homescripts, I authorize my provider to send my prescription(s) to Homescripts, and to consult with a Homescripts pharmacist regarding any medication related concerns. I AUTHORIZE HOMESCRIPTS PHARMACY TO SUBSTITUTE ANY FDA-APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PROVIDER'S ORDERS AND MY BENEFIT PLAN.

Name (Printed): ______________________________

Signature of Member or Legal Representative: ______________________________ Date: ____________

☐ Yes, I would like to receive easy-open, non-safety caps. Initials: ________

Please email the completed, saved form to customerservice@homescripts.com or fax to 877.396.5970.