Rx specialties
Pharmacy Care Made Simple

235751 Dequindre Road, Hazel Park, MI 48030
phone: 248-546-5500 | fax: 248-546-8970

ADMSSION INFORMATION FORM

PLEASE FILL IN EVERY LINE POSSIBLE TO ENSURE PROPER BILLING

REV: 5/23/17 CB

ADMISSION DATE: _____

FACILITY NAME: _____ FACILITY PHONE: _____

CORPORATION NAME: _____ PHONE: _____

CONSUMER NAME: _____ D.O.B.: _____

M.O.R.C. CASE # (IF APPLICABLE): _____ SEX: _____ S.S. # _____

ALLERGIES: _____

DELIVERY ADDRESS: _____

CITY, STATE: _____ ZIP: _____

GUARDIAN NAME: _____ PHONE: _____

CELL: _____

CONSERVATOR NAME: _____ PHONE: _____

CELL: _____

CONSERVATOR ADDRESS: _____
(BILLING ADDRESS)
CITY, STATE: _____ ZIP: _____

INSURANCE INFORMATION:

PRIMARY INS	MEDICAID	MEDICAID HMO
I.D. #: _____	ID #: _____	ID #: _____
GRP #: _____	GRP #: _____	GRP #: _____
BIN #: _____	BIN #: _____	BIN #: _____
PCN #: _____	PCN #: _____	PCN #: _____

DURABLE MEDICAL I.D. NO: _____ EFFECTIVE DATE: _____

HOME MANAGER SIGNATURE _____ DATE: _____

INSURANCE INFORMATION:

PRIMARY INS	MEDICAID	MEDICAID HMO
I.D. #:_____	ID #: _____	ID #: _____
GRP #:_____	GRP #:_____	GRP #: _____
BIN #: _____	BIN #: _____	BIN #: _____
PCN #: _____	PCN #:_____	PCN #: _____

DURABLE MEDICAL I.D. NO: _____ EFFECTIVE DATE: _____

Please attach copies of all insurance cards.

Physician's Name: _____

Address: _____

Phone Number: _____

Please list current medication and directions OR attach a copy of current MAR:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of current pharmacy: _____

Phone number of current pharmacy: _____

Contact person: _____

HOME MANAGER SIGNATURE_____ DATE: _____