

NMHC Mail
P.O. Box 407096, Ft. Lauderdale, FL 33340-7096
Enrollment/Order Form for New Participants

Please complete the following form, including the patient profile on the reverse side, and return it to NMHC Mail in the enclosed pre-addressed envelope. Be sure to sign the form and enclose the original prescriptions along with your check, money order, or credit card information.

Member Identification # _____ Group Number _____

Member Name _____ First _____ MI _____ Last _____ Employer Name _____

Your Mailing Address _____ Street _____ City _____ State _____ Zip _____

Daytime Number (____) _____ Date of Birth _____ Sex: F M

Evening Number (____) _____ MM/DD/YY _____

Patient Information (Please complete one line for each new prescription)





Patient Name _____ Relation to Member _____ Sex _____ Birthdate _____ Doctor Name _____ Doctor Phone Number _____ Other Prescription Coverage? _____

1.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	M/ F	/ /		Y/ N
2.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	M/ F	/ /		Y/ N
3.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	M/ F	/ /		Y/ N
4.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	M/ F	/ /		Y/ N

Note: Please write the member's identification number on the back of each prescription.

Childproof caps are used for safety in shipping. Check here if you want non-childproof caps included with this order. Number of prescriptions enclosed _____ X \$ _____ co-payment = \$ _____ (total amount enclosed)

Make checks payable to **NMHC Mail. DO NOT SEND CASH.** Payment is by: Check Money Order Credit Card

If paying by credit card, please indicate which card you wish to use:    

Account Number _____ Expiration Date _____

I authorize **NMHC Mail** to use this card for all future orders. **Signature** _____
 Orders received **without** payment may result in delays in processing, and therefore, extended delivery times.

Confidential Patient Profile for New Participants

Please complete the following so we can better serve you. This information is confidential, and will be used to check for potential drug interactions.
Have you ever used NMHC Mail's home delivery prescription program? YES NO

FOR THE FOLLOWING, PLEASE INCLUDE LAST NAME IF DIFFERENT FROM PLAN MEMBER:

ALLERGIES

Name	Relation to Member	None	Penicillin	Chocolate	Sulfa	Aspirin	Other (please name)
1.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						
2.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						
3.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						
4.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						

HEALTH CONDITIONS

Name	Relation to Member	Thyroid	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Other (please name)
1.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						
2.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						
3.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						
4.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent						

PLEASE READ AND SIGN:

I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, administrator, or underwriter.
I authorize NMHC Mail to substitute generic drugs in all cases when legally permissible, in accordance with applicable law, and consistent with my doctor's orders. My signature below also acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

SIGNATURE (REQUIRED TO PROCESS ORDER)

DATE (MM/DD/YY)