ANDREWS PHARMACY
Specialists In Assisted Living

NEW ACCOUNT APPLICATION

324 WESTON ROAD *WELLESLEY, MA 02482*
TEL: 781-235-1001 *FAX: 781-239-0655*
www.andrewspharmacy.com *billingdepartment@andrewspharmacy.com*

COMPLETED APPLICATIONS MUST BE SUBMITTED AT LEAST 72 HOURS PRIOR TO START DATE (EXCLUDING HOLIDAYS AND WEEKENDS) TO AVOID POTENTIAL DELAYS IN MEDICATION THERAPY. PLEASE WRITE LEGIBLY.

DATE:_____ *REQUESTED START DATE:_____*

LAST NAME:_____ FIRST NAME:_____ M.I.: ____
DOB:_____/_____/_____SSN:_____GENDER:_____
ALLERGIES:_____
MOVING FROM(HOME/HOSP/REHAB):_____
MOVING TO (FACILITY NAME):_____ROOM #:_____

RX INSURANCE (attach copies of cards if available)
ID:_____RXGRP:_____
BIN:_____PCN:_____

DEBIT/CREDIT CARD NUMBER:_____
EXP DATE:_____/_____ CCV CODE:_____ BILLING ZIP:_____
NAME ON CARD:_____
"I AUTHORIZE ANDREWS PHARMACY TO BILL THIS CARD FOR PRODUCTS AND SERVICES RENDERED ON A MONTHLY BASIS."
SIGN HERE:_____

HCP/POA BILLING ADDRESS & CONTACT INFO (STATEMENTS WILL BE MAILED TO THIS ADDRESS)
NAME:_____
ADDRESS:_____
_____
RELATIONSHIP TO PATIENT:_____
PHONE:_____EMAIL:_____
ADDITIONAL CONTACT:_____
PHONE :_____EMAIL:_____
RELATIONSHIP TO PATIENT:_____

PHYSICIAN INFORMATION
PCP:_____
TEL:_____ FAX:_____

ACCEPTABLE PRESCRIPTION FORMATS: SIGNED HARD COPY PRESCRIPTIONS, ELECTRONIC PRESCRIPTIONS, VERBAL ORDERS DIRECTLY FROM MD, SIGNED DISCHARGE MED LIST (MUST HAVE HARD COPIES/E-SCRIPTS FOR CONTROLS.) PLEASE NOTE THAT REHAB SCRIPTS ONLY COVER 30 DAYS, PLEASE CONTACT PCP IMMEDIATELY UPON DISCHARGE TO REQUEST REFILL CONTINUITY.