Intermountain Home Delivery Pharmacy

ENROLLMENT FORM

Intermountain Home Delivery Pharmacy is a great option to get the medications you need delivered right to your door. In order to get started, we need to get some information about you so that we can provide you the best service and care possible. Please complete the form below to the best of your knowledge. If you have any questions, don't hesitate to contact us at (801) 501-6910, or (855) 779-3960.

FOR NEW HOME DELIVERY PRESCRIPTIONS, PLEASE FOLLOW THESE STEPS

1. If you need to start your medication right away, please have your physician complete two prescriptions.
2. Fill one prescription at a local pharmacy of your choice and submit the other prescription to the Intermountain Home Delivery Pharmacy. Encourage your physician to write for the maximum day supply covered by your benefit plan.
3. Complete the information below for you and any family members who will utilize the Intermountain Home Delivery Pharmacy to fill prescriptions.
4. Mail this information and the original prescription(s) to:
   Intermountain Home Delivery Pharmacy
   7268 So. Bingham Junction Blvd., Suite B1
   Midvale, Utah 84047
5. Expect delivery of your order within 5 business days from the date your order is postmarked.

MEMBER INFORMATION

Name (Last, First, MI): ______________________________

Date of birth: ____________ Sex (M/F): ________ Phone: ______________

Mailing Address: ______________________________

City: ____________________ State: ________ ZIP Code: ____________

Email address (Optional): ______________________________

Medication Allergies (List all): ______________________________

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Prescription Insurance (ie. SelectHealth, Express Scripts): ______________

Cardholder ID: ____________________ BIN #: ____________________

PROVIDER INFORMATION

Doctor name (Last, First, MI):______________________________

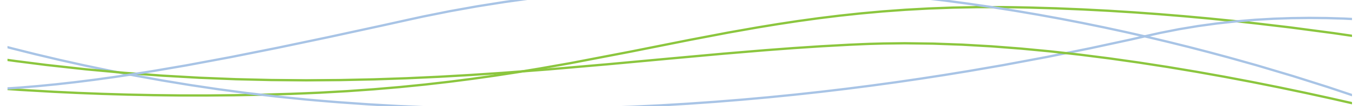
Phone: ____________________

Doctor name (Last, First, MI):______________________________

Phone: ____________________

Doctor name (Last, First, MI):______________________________

Phone: ____________________



PLEASE READ AND SIGN

By signing below, I acknowledge the following:

- The information that I provided on this form is correct to the best of my knowledge
- That Intermountain Home Delivery Pharmacy will substitute generic formulations of medication unless my prescriber indicates otherwise
- That I may contact Intermountain Home Delivery Pharmacy to speak with a pharmacist about my medications

Signature: ____ Date: ________________