NEW PATIENT MAIL ORDER PHARMACY ENROLLMENT FORM

Please fax or email the completed form to (310) 669-5609 or priorauth@dhs.lacounty.gov

PATIENT INFORMATION

Patient Name: (Last, First, Middle)			My Health LA ID:
DOB:	Gender: (Please check one) ☐ Male ☐ Female	Allergies:	
Address:	Suite, Floor, or Apt. #		
City:	State:	ZIP Code:	
Home Phone #:	Mobile Phone #:	Language Preference:	

CLINIC INFORMATION

Clinic Name:	Provider Name:	
Address:		
City:	State:	ZIP Code:
Phone #:	Fax #:	Email:

DELIVERY PREFERENCE

Specialized Packaging: (Please check one)	☐ Safety Cap **OR** ☐ No Safety Cap (Easy Open Lid)
Delivery Option (Please check one):	☐ Patient Home **OR** ☐ Clinic

Patient Attestation

I understand, by my signature below, participation in the mailing program is voluntary and dependent upon providing a valid LA County address. Failure to provide a reliable address will disqualify me from the mailing program, and subsequently I will need to arrange for medication pick-up on my own. I also understand it is my responsibility to request medication refill(s) using the automated telephone refill system (IVR) in a timely manner.

Additionally, I understand that it is my responsibility to update my address with the pharmacy if my preferred mailing address changes. **By signing this consent form, I am indicating that I fully understand the attestation and that I agree to have prescriptions mailed to the address specified above.**

Patient Signature: ____ **Date:** _____________