Patient Enrollment Form

Phone: 844-773-6779

Fax: 301-876-4395

Email: referrals@fosrx.com

Patient Information

Last Name	First Name	Spouse / Parent	
SSN#	DOB	Gender M F	Email Address
Address		Emergency Contact & Phone	
City	State / Zip	Primary Diagnosis	Secondary Diagnosis
Home Phone	Cellular Phone	Allergies	
Preferred Method of Contact		Height	Weight

Physician Information

Primary Dr.		License / DEA#
Clinic Name		Phone
Address		Fax
City	State / Zip	Nurse's Name
Secondary Dr.		License / DEA#
Clinic Name		Phone
Address		Fax
City	State / Zip	Nurse's Name

Insurance Information (Or Front and Back of Insurance Cards)

Primary Payor	PBM Name	Subscriber Name	Group#
Address		Phone	Fax
City	State / Zip	Rx BIN#	Member ID#
Secondary Payor	PBM Name	Subscriber Name	Group#
Address		Phone	Fax
City	State / Zip	Rx BIN#	Member ID#
Sales Executive	Phone	Date Submitted	Nursing Services Needed Yes No

Medication Information

Medication	Dose	Frequency

(Office Use Only)

Insurance:	
In Network: Yes No	Serviceable: Yes No
Claim Type: Pharmacy Medical	
Copay Amount: $	File Type: Paper ☐ Electronic ☐
Completed by:	Date Completed:

Notes:
