UnityPoint Health

Patient Information

First Name: _____ Middle Initial:____ Last Name:_____Date of Birth: ___/__/___

Employee Name (if patient is a family member): _____ Relationship: _____

Phone Number (Mobile/Home): _____ Phone Number (Work): _____

Email Address: _____

Home Address: _____

Work Location: _____ Employee #: _____ Affiliate ID:_____

Allergies (include medication name & reaction): _____

☐ I will pick up prescriptions at the pharmacy ☐ I want my prescriptions delivered to my work (UPH employees)

Billing Information

Pharmacy Insurance ID Number: _____ Group Number:_____

BIN Number: _____ PCN Number: _____

Copay Payment (Check One):

____Payroll Deduct

____Charge to the credit card, FSA, or HSA (Pharmacy will contact you for card information)

Release

I give permission to UnityPoint Health Pharmacy Cedar Rapids employees to:

- Deliver prescriptions for myself and my family members to my place of employment; deliveries to begin on or after **2/1/2020**. The prescription(s) may be left with either the patient, patient caregiver, or one of the authorized officials listed in Appendix A.
- Update my preferred pharmacy in the electronic health record.
- Contact my provider for additional refills if needed.
- Bill my insurance plan and selected payment method for any copays.

Patient Signature: _____ Date: _____/_____/____

*Please complete the Prescription Transfer Form on the back

Prescription Transfer Form

Patient Name:_____ DOB: _____

Current Pharmacy Name: _____ Location: _____ Phone Number: _____

Primary Care Physician: _____Location: _____ Phone Number: _____

Medication Name	Strength	Directions	Quantity Per Fill	Prescriber Name	Rx Number	Date Next Fill is Needed

Please return this form to the St. Luke's UnityPoint Health Outpatient Pharmacy by one of the following methods:

In person or by mail: St. Luke's UnityPoint Health Outpatient Pharmacy 1026 A Ave NE, Cedar Rapids, IA 52402
Fax: 319-368-5619