METIER PHARMACY CO.
Pharmacy Unscripted

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Please print clearly.

Patient Information

Patient: ______________________ First Name ______________________ Last Name ☐ male ☐ female DOB: ____________

Address: ______________ Street ______________ City ______________ State ______________ Zip

Primary phone number: ______________ ☐ Cell Alternate phone number: ______________ ☐ Cell

SS#:

Email address: ________________________________

Patient Information (continued)

What is the patient's medical condition/diagnosis relative to this application?

What drug/treatment is the patient being prescribed?

Funding Criteria Qualification

Number of people in patient's household (including patient): ______________

What is patient's approximate annual gross household income? ______________

Is patient a legal U.S. resident? ☐ yes ☐ no Does patient have insurance coverage? ☐ yes ☐ no

Insurance Information

Primary insurance: ______________ Primary health insurance phone #: ______________

Primary health insurance ID #: ______________ Primary health insurance group #: ______________

Prescription insurance: ______________ (If different from above) Prescription insurance phone #: ______________

Prescription insurance group #: ______________

Prescription insurance ID #: ______________

Provider Information

Provider's name: ______________ First Name ______________ Last Name Contact Person: ______________ First Name ______________ Last Name

Office address: ______________ Street ______________ City ______________ State ______________ Zip

Phone #: ____________ Fax #: ____________ NPI #: ____________ DEA #: ____________

If you are requesting on someone's behalf, please complete the section below.

Requester Information

Requester's name: ______________ First Name ______________ Last Name

Address: ______________ Street ______________ City ______________ State ______________ Zip

Primary phone number: ______________ ☐ cell Alternate phone number: ______________ ☐ cell

Email address: ______________ Relationship to patient: ______________

Authorization

Requester signature: ______________ Date: ______________

Please print patient name: ______________ First Name ______________ Last Name