Specialty Pharmacy Services

ENROLLMENT FORM

Our pharmacy is a great option to get the specialty 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 201-389-0107 or toll free at 1-855-424-1860.

FOR NEW SPECIALTY HOME DELIVERY PRESCRIPTIONS, PLEASE FOLLOW THESE STEPS

1. Complete the information below for you and any family members who will utilize the Valley Pharmacy Services to fill prescriptions.
2. Mail this information and the original prescription(s) to:

970 Linwood Ave, Suite 104
Paramus, New Jersey 07450

3. Expect delivery of your order within one business days from the date your order is postmarked.

PATIENT 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): ______________________________

Prescription Insurance (ie. 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: ______________

DEPENDENT #1 INFORMATION

(Fill out this section for each member of your household that will use Valley Health Pharmacy)

Name (Last, First, MI): ____________________

Relationship to member (ie. spouse, child): ____________________

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

Medication Allergies (List all): ____________________

DEPENDENT #1 PROVIDER INFORMATION

Doctor name (Last, First, MI):____________________ Phone: ____________________

Doctor name (Last, First, MI):____________________ Phone: ____________________

DEPENDENT #2 INFORMATION

(Fill out this section for each member of your household that will use Valley Health Pharmacy)

Name (Last, First, MI): ____________________

Relationship to member (ie. spouse, child): ____________________

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

Medication Allergies (List all): ____________________

DEPENDENT #2 PROVIDER INFORMATION

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 Valley Health Pharmacy will substitute generic formulations of medication unless my prescriber indicates otherwise
- That I may contact the Valley Health Pharmacy to speak with a pharmacist about my medications

Signature: ____________________ Date: ____________________