Novant Health Pharmacy - Home Delivery

255 Charlois Blvd., Winston-Salem, NC 27103
Phone: 336-718-1044 **Toll Free:** 888-718-9044
Email: NovantPharmacies@novanthealth.org

New Patient Enrollment

Need to send us a paper prescription? Please print this form and mail to us along with your **original** paper prescriptions. We will process your order and deliver to your address free of charge. We can ship your prescriptions to Florida, Maryland, North Carolina, South Carolina, Tennessee and Virginia if you choose Home Delivery. Use this form if you are a new Novant Home Delivery patient. Existing patients complete the Patient Information Update Form instead. Please complete all fields for up to 3 family members, then print and mail with **original** prescriptions to the address above.

Section 1: Patient Information & Allergies

Patient 1 First Name _____ Patient's Last Name _____ Patient's Date of Birth _____ ☐ Male ☐ Female ☐ Cardholder ☐ Spouse ☐ Dependent

☐ No Known Allergies

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 2 First Name _____ Patient's Last Name _____ Patient's Date of Birth _____ ☐ Male ☐ Female ☐ Spouse ☐ Dependent

☐ No Known Allergies

List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 3 First Name _____ Patient's Last Name _____ Patient's Date of Birth _____ ☐ Male ☐ Female ☐ Dependent

☐ No Known Allergies

List any drug allergies and any reaction you had. Include over-the-counter medications.

Section 2: Delivery Information

Street Address _____ Apartment/Ste. _____ City _____ State _____ Zip Code _____

Daytime Phone Number _____ Evening Phone Number _____ Email Address _____

Section 3: Insurance Information

Provide the information below as found on your prescription benefit card.

Name of Insurance or Health Plan _____ Identification Numer _____ Group Number _____ Bin _____ PCN _____

Cardholder's First Name _____ Cardholder's Last Name _____ MI _____

Section 4: Payment Information

This payment information will apply to all patients listed in Section 2 above.

CREDIT CARD: For your safety we do not collect credit card numbers on this form. If you would like to pay by credit card please indicate below. A member of our customer service team will contact you to collect your credit card information. Orders will not ship until a form of payment is on file. Credit card will be used for the entire co-pay and any future orders until a new form of payment is specified. We accept Master Card, Visa, FSA, and HRA cards.

☐ Please contact me to set up my credit card. Best contact number: ( )

NOVANT EMPLOYEE PAYROLL DEDUCTION: By signing, I certify that I am actively employed at Novant Health. I authorize deduction from my paycheck the sum of the co-pay incurred from use at a Novant Health Pharmacy.

☐ Novant Employee Payroll Deduction Employee ID _____ Employee Signature _____

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Section 5: Prescription Information - New or Transfer prescriptions

☐ I would like to take advantage of the automatic refill service.

New or Transfer Prescriptions? If you have additional prescriptions you would like to transfer to Novant Home Delivery please complete the sections below. We will contact your doctor or current pharmacy and transfer your prescriptions.

It's as easy as that!

Patient 1 Name _____ Patient's Date of Birth _____

Medication Name / Prescription Number	Doctor or Pharmacy Name / Phone	
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.

Patient 2 Name _____ Patient's Date of Birth _____

Medication Name / Prescription Number	Doctor or Pharmacy Name / Phone	
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.

Patient 3 Name _____ Patient's Date of Birth _____

Medication Name / Prescription Number	Doctor or Pharmacy Name / Phone	
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
		☐ I want a 30 Day Supply ☐ I want a 90 Day Supply ☐ Do not contact my doctor.
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