Xubex®
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# Medication Management Service Application

Use this application form to enroll in Xubex's medication management service. Attach prescription(s) along with completed application and mail to the address above. **You must have at least five prescriptions to use this service**.

## Patient Information

| | | | | | |
|---|---|---|---|---|---|
| First Name | | Mi | | Last Name | |
| Address | | | | Apt. | |
| City | | State | | Zip | |
| DOB | | Gender | | SSNumber | |
| Phone | | | | Alt. Phone | |
| Email Address | | | | | |

## Shipping Address if Different From Above

| | | | | | |
|---|---|---|---|---|---|
| Address | | | | Apt. | |
| City | | State | | Zip | |

## Insurance Information

| | | | | | |
|---|---|---|---|---|---|
| Name | | Bin# | | PCN# | |
| ID# | | Group# | | Phone | |

## Medicare Information

| | |
|---|---|
| Medicare ID | |

## Physician Information

| | | | | | |
|---|---|---|---|---|---|
| Physician Name | | State | | Phone | |
| Fax | | | | Alt. Phone | |

## Drug Allergies

| | | | | | |
|---|---|---|---|---|---|
| ☐ Codeine (32) | ☐ Sulfa (87) | ☐ Penicillin (70) | ☐ Tetracycline (93) | ☐ Other(00) | ☐ Unknown (00) |

| | |
|---|---|
| Additional Allergies | |

## Health Conditions

| | | | | |
|---|---|---|---|---|
| ☐ Diabetes (200) | ☐ Hypertension (300) | ☐ Heart Disease (400) | ☐ Glaucoma (500) | ☐ Stomach Disorders (600) |
| ☐ Thyroid Disease (700) | ☐ Arthritis (800) | ☐ No Known Health Condition (000) | ☐ Other(000) | ☐ Unknown (00) |

| | |
|---|---|
| Other Health Conditions | |
| Additional Comments | |

## Prescription Transfer Information

| Pharmacy Name | | Pharmacy Phone | |
|---|---|---|---|

| Medication | Rx Number | Medication | Rx Number | Medication | Rx Number |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Medications to be included in the Multi-dose Packaging

| Medication Name | Strength | Dosage | Time Taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Reminder Setting

If you would like to be reminded via a text message about your medications, please provide us with a valid cell phone number:

Reminder Phone

Please note: depending on your service there may be a charge directly from your cell phone provider.

## Payment Information

Check  Credit Card  Card  Cardholder Name

| Card Number | Exp. Date | CVV |
|---|---|---|
| | | |

If paying by check or money order, please include appropriate fee for medications in your order plus **$3.85** for shipping and handling per order.

By my signature I authorize Xubex to administer the following:
1) Use any information that I provide in my application to enroll in the program.
2) Receive and keep records of all prescriptions for the medications I receive under the Program.
3) Contact my doctor, health care provider, or pharmacist about my application for the Program, and disclose to them information contained in my application.
4) Request information from my insurer, doctor, health care provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. By signing below, I also authorize my insurer, doctor, health care provider, or pharmacist to release information about my prescribed medications and medical condition that is requested.
5) Contact my insurer and other potential funding sources on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, health care provider, or pharmacist.
6) I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Program and for a period of 3 years after my participation in the Program ends. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify Xubex of any change in my insurance eligibility.

Applicant Signature  Date