Free Blood Glucose Monitor Form

XUBEX® Pharmacy Services
Affordable Quality Care
www.Xubex.com
P.O. Box 1244 • Winter Park, FL 32790-1244
Toll free: 866-699-8239 • **Fax 407-671-7960**

Please use this form to apply for Xubex's Free Blood Glucose Meter offer. Please note that if you have Medicare, any other federally or state funded prescription coverage, or private prescription insurance you may not be eligible for this offer. However, we may be able to process your request through your insurer and there may be little to no out-of-pocket expense to you. **You must have your physician's signature on this form to participate in this offer.** You may submit this form via the address or fax listed above. Faxes must come from physician's office. Order will be shipped within 7-10 business days of receipt. This offer is not for a specific brand of glucose monitor. The brand you receive is based on availability. Quantity limitations apply. Offer may end or be amended without notice. Refills for your monitor may be purchased from Xubex by either visiting www.Xubex.com or calling our Patient Care Team toll free at (866) 699-8239.

PATIENT INFORMATION			
First:	Last:		M.I.:
Address:			
City:	State:	Zip:	
Shipping Address: ☐ Same as Above			
Date of Birth:	☐ Male ☐ Female	SSN:	
Best Phone:	Email:		

INSURANCE INFORMATION			
Do you want us to bill your insurance? ☐ YES ☐ NO	**Do you have Medicare?** ☐ YES ☐ NO	Medicare ID#:	
Prescription Insurance Company:		Phone:	
BIN #:	PCN #:	ID #:	
Group#	Additional Information:		

PHYSICIAN'S INFORMATION		
Name:	City/State:	
Phone:	Fax:	
DEA:	NPI:	Lic.:

☑ PRESCRIPTION	
Rx **Blood Glucose Monitor**	
Instructions:	
Patient's Signature:	Date:
Physician's Signature:	Date:

FOR OFFICE USE ONLY:		
Patient Code:	Date Received:	By:
☐ No Prescription Attached ☐ No Payment ☐ Incomplete Application ☐ Contact Physician ☐ Bill Ins. ☐ Transfer		

Patient's signature authorizes Xubex to administer the following:

1. Use any information that I provide in this registration form to enroll in the Xubex Patient Assistance and Mail Order program.
2. Receive and keep records of all prescriptions for the medications I receive under the program.
3. Contact my doctor(s), health care provider(s), and/or pharmacist about my registration for the program, and disclose to the information contained in this registration form.
4. Request information from my insurer(s), physician(s), health care provider(s), and/or pharmacist about the prescribed medications I receive or will receive while enrolled in the program and about my medical condition. By signing below, I authorize my insurer(s), physician(s), health care provider(s), and/or pharmacist to release information about my prescribed medications and medical condition that is requested by Xubex.
5. Contact my insurer(s) 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 this registration form or information about my prescribed medications and medical condition that has been provided by my physician(s), health care provider(s), and/or pharmacist.
6. I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I am enrolled and participate in the program and for a period of three (3) years after my participation in the program ends. Furthermore, I certify that the information provided on this registration form is complete and accurate to the best of my knowledge and agree to notify Xubex of any change in my insurance eligibility.
7. By submitting this application, I confirm that I have read, understand, and agree to the Xubex privacy policy posted at: http://www.xubex.com/privacypolicy.aspx