Patient Intake Form-PAIN MANAGEMENT

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XUBEX® Specialty Pharmacy Services
www.Xubex.com

Fax Enrollment Form To:

866-495-3304

DATE_____

PATIENT INFORMATION			
First:	Last:	M.I.:	
Date of Birth:	SSN:	☐Male ☐ Female	
Best Phone:	Alt. Phone:	Email:	
Address:	City:	State:	Zip:
(Check all that apply) ☐New Patient ☐ Update ☐ Prescription Transfer			

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION			
Prescription Card:	Name of Insurer:	ID#:	
Phone:	BIN#	PCN:	Group#
Primary Insurance Policy Holder:	☐ Same as Patient	☐ Other	
Primary Insurance:	Name of Insurer:	ID#:	
Phone:	BIN#	PCN:	Subscriber:
Secondary Insurance:	Name of Insurer:	ID#:	
Phone:	BIN#	PCN:	Subscriber:

DELIVERY INSTRUCTIONS	
Please Deliver To: ☐ Patient's Home ☐ Prescriber's Office	**Deliver By:**

ADDITIONAL INSTRUCTIONS
IMPORTANT: Please attach a copy of the patient's prescription for Abstral and the patient's insurance information.