General Injectable
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ _____
Contact Phone: _____ _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Shield of RI**
Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-9 Code):

☐ _____
☐ _____
☐ _____
• Date of Diagnosis: _____

Lab Data/Allergies/Additional Comments:

_____
_____
_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

_____ _____
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)