



Fax Referral To: 800-323-2445

Phone: 866-278-6634

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

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): _____

Lab Data/Allergies/Additional Comments: _____

- ☐ _____
☐ _____
☐ _____

• Date of Diagnosis: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

PRODUCT SUBSTITUTION PERMITTED (Date) _____

DISPENSE AS WRITTEN (Date) _____

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