Broadway Family Pharmacy

*To fill this form out online, please scan the QR code

ENROLLMENT FORM

FAX OR ESCRIPT ALL PRESCRIPTIONS TO

Broadway Family Pharmacy
601 Amsterdam Ave. | New York, NY 10024
Toll Free Phone & Fax: 888-609-2064
Email: ny_pharmacists@340bpharm.com

CLINIC NAME:	☐ 340B Regular	☐ PrEP/STD
TODAY'S DATE:	340B Eligible:	☐ Yes ☐ No
DELIVERY INFORMATION (REQUIRED)	PCP:	
☐ PATIENTS ADDRESS (See Address information under PATIENT DEMOGRAPHICS Section)		
☐ OTHER ADDRESS:		
CURRENT PHARMACY INFORMATION	Pharmacy:	Phone: Fax:

PATIENT DEMOGRAPHICS (REQUIRED)	Address:		
Last Name:	First Name:	Middle Name:	
Preferred Name:	Birth Date:	Pronouns:	
Sex (check one): ☐ Male ☐ Female	Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other:		
Street Address:	P.O. Box:	City, State, Zip:	
Email Address (if available):	Phone Number:	Emergency Contact:	Emergency Contact Phone:
Authorized Representative (Covered Entity Name or Provider Group) Name:	Phone:	Email:	

Please attach copy of driver's license or photo ID front and back as well as Insurance Cards front and back (Including prescription benefits)*

Policy Insurance:	Patient ID:	Rx Group Number:
PCN:	BIN:	Subscriber's Name:
Patient Relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Check to Indicate Front/Back of Insurance Card is Attached	

PATIENT CLINCALS (REQUIRED)	***Please send additional sheet if needed for complete medication list***
Patient's Diagnosis [include !CD-10 on this form or ERx]:	
Patient's Other Medical Conditions:	☐ No other medical conditions
Any known Allergies or Sensitivities:	☐ No known allergies
Pertinent Medical History:	☐ No additional information
Is patient able to self administer the medication prescribed? ☐ Yes ☐ No	If "No", provide details:

Other Medications Including OTCs & Supplements	*Dose, Route, Frequency*	*Diagnosis*

PATIENT CLINCALS (Optional)		
PrEP: Date of last negative result:	HIV: Current CD4 (T-cell) count:	HIV: Resistance test result:
HIV: Date of last positive result:	HIV: Current viral load:	HCV: Current viral load:
HCV: Genotype:	HCV: IL-28B:	HCV: Liver Fibrosis:

By signing below, I authorize the release of PHI needed to process claims for my medication, including medical and insurance benefit information. I also authorize the pharmacy to contact my current pharmacy to transfer my prescriptions, deliver medication to the address listed on this form, contact my authorized representative if I cannot be reached to confirm shipping details, and bill my insurance company for prescriptions filled on my behalf.

Patient/Guardian/Representative Signature: Date: ***SIGNATURE REQUIRED***