LEE HEALTH

Lee Health Plan Pharmacy Registration Form

Mail or Fax this completed form to:

LEE HEALTH PLAN PHARMACY
636 Del Prado Boulevard, Cape Coral, FL 33990
Phone 239-424-3197 • Fax 239-424-4087

Patient Information

Name: ______________________________

Birthdate: ____________________ Sex: ☐ Male ☐ Female

Identification Number (11 digit number from Health Plan card): ____________________

Street Address: ______________________________

City / State / Zip: ______________________________

Phone Number: ____________________ E-Mail Address: ____________________

(Providing your e-mail address authorizes us to email you information about your account or our services. It will not be shared with any outside party except our shipping vendor for package tracking purposes only. If other household members also use this e-mail, they may be able to access your health information).

Allergies – *Check or list all known allergies*

☐ No Known Allergies ☐ Penicillin Allergy ☐ Sulfa Allergy ☐ Other Allergy – List ____________________

____

List all PRESCRIPTION medications you take on a regular basis:

Medication Name	Prescriber Name & Phone Number	Should pharmacy contact your provider for a 90 day prescription?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Dependent Information

Dependent Name: ______________________________

Birthdate: ____________________ Sex: ☐ Male ☐ Female

Identification Number (11 digit number from Health Plan card): ____________________

Allergies – *Check or list all known allergies*

☐ No Known Allergies ☐ Penicillin Allergy ☐ Sulfa Allergy ☐ Other Allergy – List ____________________

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List all PRESCRIPTION medications you take on a regular basis:

Medication Name	Prescriber Name & Phone Number	Should pharmacy contact your provider for a 90 day prescription?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Dependent Information

Dependent Name: ______________________________

Birthdate: ______________________ Sex: ☐ Male ☐ Female

Identification Number (11 digit number from Health Plan card): ______________________

Allergies – *Check or list all known allergies*

☐ No Known Allergies ☐ Penicillin Allergy ☐ Sulfa Allergy ☐ Other Allergy – List ______________

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List all PRESCRIPTION medications you take on a regular basis:

Medication Name	Prescriber Name & Phone Number	Should pharmacy contact your provider for a 90 day prescription?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Shipping

- Your order will be shipped via UPS at no charge to the address you provided.
  Please allow 14 days for your prescription to be processed and shipped.
- **You must contact the pharmacy directly to report any change of shipping information.**
- Prescriptions *cannot* be shipped to an Lee Health owned location.
- Express Delivery (3 business days) is available for an additional fee of $25. Overnight service and/or Saturday delivery might be available for $50. Requests for resending medications due to the recipient's failure to notify Lee Health Plan Pharmacy directly of a change in shipping address will be charged $20 delivery fee.

Payment Information

- Payment is due prior to shipping each order. Orders received without payment may result in a delay of processing.
- Payment may be made by credit card or check. Payment by credit card is preferred.

☐ Payment by CREDIT CARD (provide information below):

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Credit card #: ______________________ Expiration Date (mm-yyyy): ______ - _______

☐ Payment by CHECK

Make check payable to LEE HEALTH PLAN PHARMACY. There will be a $25 fee for all returned checks.

Do Not Send Cash.

By returning this form, you consent to the use and release of your health information and that of your covered dependents to your health plan and health care providers/agents for health benefits management.

Printed Name: ______________________________

Signature: ______________________________ Date/Time: ______________________