

To enroll online: Go to www.rx.procarerx.com, click on “New Customer Registration”

To manually process your registration, please complete the form below and follow the mailing instructions at the bottom.

SERVICE REGISTRATION AND PRESCRIPTION ORDER FORM

(Please include your prescription with this form.)

A. PATIENT INFORMATION				
Last Name		First Name		Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Home Phone	Cell Phone	
Mailing Address		City	State	Zip Code
Physical Address		City	State	Zip Code
B. HEALTH INSURANCE INFORMATION				
Name of Policyholder		Patient's Contract Number	Group Number	
Relationship to Policyholder Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>				
C. PHYSICIAN INFORMATION				
Physician Name				
Telephone			Fax	
D. HEALTH HISTORY				
Allergies: Iodine <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa <input type="checkbox"/> None <input type="checkbox"/> Others (Specify) <input type="checkbox"/>				
Health Conditions: Thyroid <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hypertension <input type="checkbox"/> Epilepsy <input type="checkbox"/> Ulcers <input type="checkbox"/> Arthritis <input type="checkbox"/> Heart Conditions <input type="checkbox"/> Others (Specify) <input type="checkbox"/>				
Current Medications: (specify dose)				
E. METHOD OF PAYMENT				
Credit Card: Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/>				
Card Number			Expiration Date	
Payment is due with each order. This credit card will be used for this and future orders unless another card is submitted and authorized.				
Signature			Date	

ProCare PharmacyCare LLC will dispense equivalent generic medications as allowed by law and with your physician's authorization. If you wish for your prescription to be "dispensed as written" (no generics), please check the box below:

Do not fill with generic medications, please dispense as written. (By checking this box, a higher copayment amount may apply.)

Please send this form and the original prescription to the following address:

ProCare PharmacyCare, 2650 SW 145th Avenue, Miramar, FL 33027-6606

Pharmacy Hours: Monday – Friday 9a to 6p (ET), Saturday 9a to 1p (ET)

PH 800-662-0586 | FAX 800-662-0590 | TTY LINE 711

Email: HomeDelivery@ProCareRx.com

24/7 Customer Care Center: 855-828-1484

The physician may fax the prescription to ProCare PharmacyCare to be processed. Please call the pharmacy prior to having your doctor send the prescription to confirm your shipping address and provide payment: 1 (800) 662-0586, Option 2.