



Indiana University Health

IU Health Retail Pharmacy Network- New Patient Enrollment Form

Instructions

To begin the process, email your completed New Patient Enrollment Form to ATP@iuhealth.org or via fax to 317-968-1117. The pharmacy staff will triage your enrollment form to your chosen IU Health Pharmacy, begin to work with your providers and current pharmacy to transition your care. If interested in mail order pharmacy services, you should select Advanced Therapies Pharmacy.

To streamline enrollment and prevent future delays in the refill process we also recommend you:

- 1) **Notify your prescribers of your change in preferred pharmacy** so future prescriptions are sent to the appropriate IU Health Pharmacy instead of your previous pharmacy
- 2) Ask your providers to **send new 90-day prescriptions to your chosen IU Health Pharmacy** as it will eliminate potential delays related to the transfer process with external pharmacies.

Please allow **7 to 10 business days** to receive your prescriptions.

Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle Initial	<input type="text"/>
Date of Birth	<input type="text"/>
Gender	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Prefer not to say

Prescription Insurance Information

Insurance ID	<input type="text"/>
RX Bin	<input type="text"/>
RX PCN	<input type="text"/>
RX Group	<input type="text"/>
Name of Insurance Cardholder	<input type="radio"/> Same as Patient above <input type="radio"/> Other <input type="text"/>

Select which IU Health Pharmacy you would like to use (select one)

Specialty and Mail Order -

☐ Advanced Therapies Pharmacy

Retail Pharmacy Pick-Up Options

Academic Health Center

☐ Methodist Retail Pharmacy ☐ Riley Retail Pharmacy ☐ University Retail Pharmacy

Indy Suburban Region

☐ North Retail Pharmacy ☐ Saxony Retail Pharmacy ☐ West Retail Pharmacy

East Central Region

☐ Ball Pavilion Community Pharmacy
☐ Blackford Pharmacy ☐ Ball State University Health Center Pharmacy
☐ Yorktown Pharmacy

South Central Region

☐ Bloomington Retail Pharmacy

West Central Region

☐ Arnett Retail Pharmacy

Shipping Address

Street Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>
Preferred Phone Number	<input type="text"/>
Billing Address	<div><div><input type="radio"/> Same as Shipping Address</div><div><input type="radio"/> Other <input type="text"/></div></div>

Patient Medical History

Allergy

- ☐ None
- ☐ Aspirin
- ☐ Cephalosporin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other

Health Conditions

- ☐ None
 - ☐ Arthritis
 - ☐ Asthma
 - ☐ Diabetes
 - ☐ Acid Reflux
 - ☐ Glaucoma
 - ☐ Heart Problem
 - ☐ High Blood Pressure
 - ☐ High Cholesterol
 - ☐ Migraine
 - ☐ Osteoporosis
 - ☐ Prostate Issue
 - ☐ Thyroid
 - ☐ Other
-

Current Pharmacy & Prescription Information

Do you currently use an IU Health Pharmacy? ☐ Yes ☐ No

Current Pharmacy Name

Current Pharmacy Phone Number

How many medications would you like to transfer to an IU Health Pharmacy?

	Drug Name	Strength	Prescription #	Prescriber	Prescriber Phone #
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Please note if using mail order pharmacy services, the pharmacy will not ship any prescriptions to you based on the completion of this form without first talking to you. If there are any copay/medication expenses, the pharmacy team will discuss payment options. If you are an IU Health employee, be sure to ask about payroll deduct as an option to further simplify the process.

Please contact me at the following telephone number during daytime hours to collect my credit card information.

Pharmacy Communication Opt-In

In an effort to communicate with patients in a more efficient and timely manner, IU Health Pharmacies can use phone, e-mail and text communications to contact our patients regarding non-urgent messages. By providing your information and signing below, you acknowledge your understanding that this program is completely voluntary and that text messaging rates & fees may apply as determined by your cellular provider. If at any time you wish to discontinue receiving this service from an IU Health Pharmacy, you must contact the pharmacy staff directly in order to discontinue this service.

Patient Name

E-mail Address

Cell Phone

Alternative Phone

Please select **one** preferred method of contact:

☐ Phone Call Alerts

☐ E-mail Alerts

☐ Text Alerts

Patient Signature

Date Signed

USE OF UNSECURE ELECTRONIC COMMUNICATIONS

If you choose to communicate with us or any of your IU Health providers via unsecure electronic communication, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication. Before using any unsecure electronic communication to correspond with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others or messages stored on unsecured, portable electronic devices. By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that use of email is not intended to be a substitute for professional medical advice, diagnosis or treatment. Email communications should never be used in an emergency.