AmherstMeds
Employee Program

Dependent Form

MEMBER #:

***FAX* DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL FREE TO: 1-866-715-(MEDS)6337**
OR
***MAIL* TO: *AmherstMeds*, P.O. BOX 44650, DETROIT, MI., U.S.A. 48244-0650 PHONE TOLL FREE: 1-866-893-(MEDS)6337**

PATIENT INFORMATION: **Birthdate** _____ ❑ **SPOUSE** ❑ **DEPENDENT**
DD/MM/YYYY

Phone (Home) **Phone (Work)**

First Name (please print) **Initial** **Last Name**

Street Address

City/State **Zip Code**

NOTE:
Please request a **3-month** supply of medication with **3 refills.**

New-to-you meds must be tried for 30 days before ordering through this program.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements. *Ex. Lipitor* *(This is NOT a prescription.)*	**Strength** *Ex. 10 mg*	**Reason for Taking** *Ex. Cholesterol*	**Daily Use** *Ex. One a day*

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.) ❑ **Male** ❑ **Female**

(i) Operations: eg. Hysterectomy, Gall Bladder, Heart Operations, etc. _____

(ii) Hospitalization: (stays in hospital past 5 years) _____

(iii) Present Illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc. _____

(iv) Drug Allergies: ☐ NO ☐ YES If yes, please specify: _____

Physician's Name: **Signature** *(optional)* **Date** *(DD/MM/YY)*

AUTHORIZATION
I certify this to be a true and accurate statement of my Dependent's Medical History. I confirm that he/she has and will be regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the medication (s) ordered through this program for a period of more than 30 days. I certify that I have read and understand the terms of agreement on the reverse and that the information provided by me is accurate and true.
I request and authorize the Town of Amherst, M.A., to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service. A Guardian/Parent *must sign* for an Underage Dependent.

Patient Name: **Signature** **Date** *(DD/MM/YY)*

Member / Guardian Name: **Signature** **Date** *(DD/MM/YY)*

THIS FORM MUST BE ACCOMPANIED WITH THE WRITTEN PRESCRIPTION (S) OF YOUR U.S. PHYSICIAN.