AmherstMeds
Employee Program

CanaRx
Dependent Enrollment 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**
DD/MM/YYYY ❑ **DEPENDENT**

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 medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

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 **IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18**
I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, 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 above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse and that the information provided above is accurate and true. I request and authorize the Town of Amherst, MA, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Parent's/Guardian's Signature: **Date:** *(DD/MM/YY)*

AUTHORIZATION **IF THE PATIENT IS THE SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER**
I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medication for a period of more than 30 days. I certify that I have read, understand and agree to 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, MA, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

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