



Employee Program

Subscriber 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 _____ DD/MM/YYYY	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.
Phone (Home)	Phone (Work)		
First Name (please print)	Initial	Last Name	
Street Address			
City/State	Zip Code		

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

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 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 medications 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.

Patient Signature _____ Date (DD/MM/YY) _____

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