



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: SLCMeds, P.O. BOX 44650, DETROIT, MI., 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 and their strengths. <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. Twice Daily</i>

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

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

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

(iii) Present illness: (ongoing) e.g., 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 she/he 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 St. Lawrence County, NY, 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 St. Lawrence County, NY, 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) _____