BRAND SCRIPTS

EMPLOYEE PROGRAM

CRX International
Subscriber Enrollment Form

Member ID#:

FAX DIRECTLY **FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-215-7874**
***Or MAIL* TO: BRAND SCRIPTS, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-488-7874**

PATIENT INFORMATION: **Birthdate** _____ 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** 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: 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
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 the medications ordered through this program 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 Intelsat 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)*