Appalachian Specialty PHARMACY

wncap

WNCAP/Pharmacy Name Patient Enrollment Form

Patient Name:	DOB:	Patient Needs Medication By:
Preferred Phone:	Ok to leave a detailed message? ☐ Y ☐ N	
Alternate Phone:	Ok to leave a detailed message? ☐ Y ☐ N	
Designated contact:	Relationship:	Phone:
Email:		
Case Manager:	Email:	CM Phone:

Patient Address:	Delivery Address (if different):

Preferred delivery method: ☐ Delivery ☐ Pick Up	Signature Required for Delivery? ☐ Y ☐ N
Delivery Notes:	

Patient Allergies:
Current Medication(s):
Current Medical Condition(s):
Blister Pack Medications: ☐ Y ☐ N
If Yes, ☐ Once Daily (30 day pack) **OR** ☐ Four times daily (Morn, Noon, Evening, Bedtime) weekly packs (28 days)

Primary Insurance:	Secondary Insurance:
ID:	ID:
Rx BIN:	Rx BIN:
PCN:	PCN:
Rx Group:	Rx Group:

Patient eligible for the 340B Program? ☐ Y ☐ N	Provider Name:
☐ RW designation OR ☐ STD designation	

Transfer in from Pharmacy:	Phone:
Medication(s):	

Additional Notes to Pharmacy:

Appalachian Specialty Pharmacy
932 Hendersonville Rd Suite 106
Asheville, NC 28803
Phone: (828) 242-4269 Fax: (828) 785-1437
wncap@appalachianrx.com