US Bioservices
AmerisourceBergen Specialty Group

US Bioservices patient enrollment form
FAX: (888) 418-7246
PHONE: (888) 518-7246

TX

PATIENT INFORMATION (please print clearly)

Last Name

First Name

Social Security No. | Date of Birth

Guardian/Caregiver

Home Phone | Work or Mobile Phone

Home Address

City, State, Zip

PATIENT INSURANCE INFORMATION

Medical Insurance (Fax Copy of Card) | Medical Insurance Phone

Subscriber Name

Policy # | Group #

Prescription Card (fax copy of card) | Prescription Card Phone

Policy # | BIN / PCN

Medicare Number | Medicaid Number

PRESCRIBER INFORMATION

○ MD ○ DO ○ NP ○ PA

Prescriber Name (please print)

Practice Name

Prescriber Address

City | State | Zip

Phone | Fax | Backline Phone Number

License # | NPI # | UPIN # | DEA #

Office Contact | Supervising Physician (if applicable)

PRESCRIPTION

[Tape Prescription Here]
and fax to US Bioservices

CLINICAL INFORMATION

Patient Weight _____ (circle one) lbs kg

Allergies _____

Diagnoses _____

MEDICAL HISTORY (please include any relevant medical history or attach H&P)

NURSING / LABS

Nursing: ○ Provide nurse for patient injection training, lab draws or administration of medication as ordered

Labs: ○ _____

Deliver to: ○ Patient's Home ○ Prescriber Office
○ Other: _____

Prescriber Signature **Date**
No stamps. Prescriber signature required.
○ Hold Shipment until notified by prescriber