This information will help us streamline your care by providing electronic prescriptions when available.

Patient Name: _____ Date of Birth: _____

Do you have a pharmacy benefit? …Yes – complete sections 1, 2 and 3
…No – complete sections 2 and 3

Section 1 – Pharmacy Benefit

Your Pharmacy Carrier is:

…Medco …Caremark …Cigna …Aetna …Other – please indicate: _____

Name of Primary Insured for Pharmacy Benefit: _____ ID#: _____

Section 2 – Preferred Pharmacy

If you have a preferred or local pharmacy for your general medications, please provide the following information. If you indicate a large brand store such as Duane Reade, CVS, Walgreens, ShopRite, etc. – you must indicate the store number (for example, CVS #2254) as well as the address. Specialty pharmacies can be found

Pharmacy / y1 q

_____ _____ _____

_____ Fax: _____

others. Specialty pharmacies also participate in savings programs for self -pay/cash patients.

Pharmacy : _____ Store #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

NYULFC use only – Entered by: _____ Date: _____