NEW PATIENT ENROLLMENT FORM

Diabetes Testing Supplies

Home Delivery Program

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Other Phone #: _____

Social Security #: _____ Date of Birth: _____ Sex: _____ Marital Status: _____

Next of Kin: _____ Emergency Phone #: _____

Signature: _____

By signing, you are authorizing MedEnvíos to contact you by telephone

INSURANCE INFORMATION

Medicare #: _____ Part B Effective Date: _____

Name of Secondary Insurance: _____

Insurance Phone: _____ Policy or ID: _____ Group: _____

MEDICAL INFORMATION

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Date of Last Visit: _____

REFERRING AGENCY INFORMATION

Contact Person: _____ Phone: _____ Ext: _____

Special Instructions: _____

PLEASE FAX COMPLETED FORM TO 1-888-856-2844

MedEnvíos HEALTHCARE

Note: Within 24 hours, a MedEnvíos enrollment specialist will contact the patient to complete the enrollment process.

7415 Corporate Center Drive – Bay B
Miami, FL 33126
Telephone: 1-800-315-9944