New Account Application

324 Weston Road, Wellesley MA 02482
Phone: (781)-235-1001 **Fax** (781)-239-0655
Email: billingdepartment@andrewspharmacy.com
www.andrewspharmacy.com

Today's Date:___________
Start Date:______________
Start Time: AM/PM

For best results, please submit completed applications 72 hours prior to Start Date. Incomplete applications will result in delays.

RESIDENT INFORMATION

LAST NAME:______________________ FIRST NAME:__________________ MIDDLE INITIAL:_______

Date of Birth:_______________ Social Security #:__________________ Gender:_________

Home Address:____

City:_____________________________ State:_______ ZIP:_______

Allergies:____

FACILITY DESTINATION

FACILITY NAME:____Room Number:_________

FACILITY ADDRESS:____________________________________City:___________State:______ZIP___

Moving From (circle one): Home Rehab/Hospital Assisted Living
Hospital/Rehab Facility Name:__________________________________ Phone:_____________
Please be advised that if the resident has a supply of medication prior to moving in, most insurances will not cover an Early Refill. Please contact their Prescription Drug Plan for accommodations and overrides.

PHYSICIAN INFORMATION

Physician Name	Specialty	Address	Phone	Fax

If Patient is currently hospitalized or in rehab, please fax a Signed Medication List prior to discharge to 781-239-0655.
If Patient is moving from Home, their Prescribing Doctors have the option to e-scribe, call 781-235-1001 directly, or fax a Signed Medication List to 781-239-0655

BILLING INFORMATION

Prescription Drug Insurance Member ID:____
RXGRP:_______________RXBIN:_____________RXPCN:___________(please attach copy of card if avail)
Debit/Credit Card:____
Expiration:______/_______ CVV Code:________ Cardholder Name: ________________________
Billing Address (statements will be mailed to this address):_____________________________
__________________________________City:__________________State:_________ ZIP:_________
HCP/POA/Family/Additional Contact Info: Name:___________________________Tel#:_______________
email:____

Please read and sign: "I authorize Andrews Pharmacy to bill my credit/debit card on a recurring basis for all services rendered" Name:____Date:____/_____/________