**Please return completed form by fax to: 877-678-5401**
**To enroll over the phone, please call us at: 877-678-5400**

## PERSONAL INFORMATION

NAME: _____ MALE _____ FEMALE _____
Last First MI

ADDRESS: _____
Street City State Zip

PHONE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

EMAIL: _____

## CLAIM INFORMATION

DATE OF INJURY: _____ INJURED BODY PART(S): _____

NAME OF EMPLOYER: _____ PHONE: _____

ADDRESS: _____
Street City State Zip

NAME OF ATTORNEY: _____ PHONE: _____

WORKERS COMPENSTION INSURANCE CARRIER: _____

ADDRESS: _____
Street City State Zip

TEL. NO: _____

CLAIM NUMBER: _____ ADJUSTER'S NAME: _____

## MEDICAL INFORMATION

PHYSICIAN'S NAME: _____ PHONE: _____

ADDRESS: _____
Street City State Zip

**DIAGNOSIS CODES (ICD-9):** _____

MEDICATIONS: ALLERGIES:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

The information I have given is accurate and complete. I authorize Summit Pharmacy, Inc. to receive payment for medical benefits. I authorize all medical or other information requested by Summit Pharmacy, Inc. to process my claim(s) to be released from any doctor, hospital or other provider who participated in my treatment and care.

PATIENT'S SIGNATURE: _____ DATE: _____

**FOR OFFICE USE ONLY**