EPIC PHARMACY

Thank you for choosing EPIC Pharmacy
Please fax completed form to: 866-720-6337
For questions, please call us at: 866-720-6338

ATTORNEY ENROLLMENT FORM

My claim is: ____ Workers' Compensation ____ Personal Injury *(check one)*

PERSONAL INFORMATION

Last Name:	Middle Name:	First Name:
Date of birth:	SSN:	____ Male ____ Female *(check one)*
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	E-mail:

CLAIM INFORMATION
**Workers Compensation only*

Date of Injury:	Claim Number:
Injured Body Parts*:	
Name of Employer*:	

Address*:		Phone*:
City*:	State*:	Zip Code*:
Workers' Comp or Auto Insurance Carrier*:		
Address*:		Phone*:
City*:	State*:	ZIP Code*:
Adjuster's Name*:		Phone*:

MEDICAL INFORMATION

Physician's Name:		
Name of Practice:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	E-mail:

ATTORNEY INFORMATION

Attorney's Name:		
Law Firm:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	E-mail:

MEDICAL AUTHORIZATION
**Please choose 1 of the following options*

I prefer for EPIC to call me each time for authorization to fill a medication: ____ YES ____ NO

I authorize EPIC to proceed without calling for a spend limit less than: ____ $500/month ____ $1000/month ____ $_____/month

ATTORNEY SIGNATURE

The undersigned attorney accepts absolute and full responsibility for services rendered to the Patient. Attorney further agrees to protect the interests, assignments, and privileges of recourse to EPIC Pharmacy for bill payment, at the underlying provider's full billed rate.

Attorney Signature	Date: