NextLevelHealth
A healthier you. A healthier community.

Member Enrollment Form
NLH Member Mail Order Service

STEP 1 - Personal Information

Name: _____ Date of Birth (mm/dd/yy): _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Mobile Phone: _____

Email Address:* _____

Emergency Contact: _____ Phone: _____

Relationship to Member: _____

Allergies: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa Other: _____

Health Condition(s): ☐ Thyroid ☐ Diabetes ☐ Arthritis ☐ Heart Conditions ☐ High Blood Pressure

☐ Asthma ☐ High Cholesterol Other: _____

**By providing your email address, you consent to receive email notifications regarding your prescription benefits, as well as other information on behalf of Homescripts and Envolve Pharmacy Solutions. You may opt out of this email service at any time by contacting us or following the opt-out instructions included in each email you receive.*

STEP 2 - HEALTHCARE PRACTITIONER INFORMATION

Name (Printed): _____ Phone: _____

Office Location: _____

STEP 3 - PRESCRIPTION INSURANCE INFORMATION

Policyholder (if different than above): _____

Relationship to Member: _____

Cardholder ID #: _____ Rx Group: _____

Rx BIN #: _____ PCN/Plan Code: _____

Insurance Name: _____ Insurance Phone: _____

(Turn over to complete)

Toll Free: 1.888.239.7690
TTY: Please dial 711 for phone relay assistance

Customer Service Hours:
M-F 8am - 8pm EST, Sat 10am - 1pm EST

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Homescripts Enrollment Form

STEP 5 - MEDICATION HISTORY

Please list all prescription and over-the-counter medications you are currently taking.

Medication Name	Strength

Medication Name	Strength

STEP 6 - NEW PRESCRIPTION(S) INFORMATION

1

Send Prescriptions By Mail To:

Homescripts Pharmacy
Attn: New Member Enrollment
500 Kirts Blvd., Suite 300
Troy, MI 48084

OR

2

Ask Your Provider to Call or Fax Prescriptions To:

Homescripts Pharmacy
Attn: New Member Enrollment
500 Kirts Blvd., Suite 300 | Troy, MI 48084
Phone: 1.888.239.7690 | TTY: Please dial 711 **OR**
Fax to: 877.396.5970

*US law prohibits **patients** from emailing or faxing prescriptions directly to the pharmacy.*

STEP 7 - SPECIAL INSTRUCTIONS

Please include any special instructions regarding your order:

_____

STEP 8 - PLEASE READ, SIGN, & DATE

I certify that the information provided on this form is correct and authorize the release of all information to Homescripts, I authorize my provider to send my prescription(s) to Homescripts, and to consult with a Homescripts pharmacist regarding any medication related concerns. I AUTHORIZE HOMESCRIPTS PHARMACY TO SUBSTITUTE ANY FDA-APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PROVIDER'S ORDERS AND MY BENEFIT PLAN.

Name (Printed): _____

Signature of Member or Legal Representative: _____ Date: _____

☐ Yes, I would like to receive easy-open, non-safety caps. Initials: _____

Please email the completed, saved form to customerservice@homescripts.com OR fax to 877.396.5970.