Convenience

- After you enroll in our service, your doctor easily can send new prescription orders for you by phone, mail, fax, or ePrescribe. When the mail order pharmacy gets a prescription directly from your doctor, you will be called first to confirm that you want the drug(s).
- Our pharmacy team members will contact you for refill reminders.
- You can receive up to a 90-day supply of drugs.
- For any questions or concerns about your drugs, you can speak to one of our pharmacists by phone or email at Homescripts.com.

Packaged for Safety

Our pharmacists process all mail service prescriptions and mail your drugs in plain, tamper-proof packages. Refrigerated drugs arrive in a temperature-safe package.

Enroll Today

Complete enrollment using one of the options below:

- **OPTION 1**
  Email. Send completed form to customerservice@homescripts.com.

- **OPTION 2**
  Phone. Call to enroll at 1-888-239-7690.

- **OPTION 3**
  Mail. Mail your completed enrollment form to Homescripts.

Easy Refills

You can refill your prescriptions in three simple ways:

- **OPTION 1**
  Online. Log into Homescripts.com.

- **OPTION 2**
  Phone. Call us at 1-888-239-7690. You can leave a message without having to wait to speak with someone.

- **OPTION 3**
  Mail. Mail your completed consent form that comes with every package.
Member Enrollment Form

STEP 1 - PERSONAL INFORMATION

Name: _______________________________ Date of Birth (mm/dd/yy): _______________________
Address: _______________________________ City: _______________________________ State: ______
Zip Code: ___________ Home Phone: _______________________________ Mobile Phone: _______________________
Email Address:* _______________________________ Phone: _______________________________
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 Enolve 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 Number: _______________________
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 Number: _______________________

STEP 4 - PAYMENT INFORMATION

Credit Card Type: □ Visa □ Mastercard □ Discover □ Amex □ Use this card for future orders? □ Yes □ No
Credit Card #: _______________________________ Expiration Date: ______/_______ □ Is this an FSA card? □ Yes □ No
Cardholder Name: _______________________________ Cardholder Signature: _______________________

FRM015294EO000

(turn over to complete)
Member Enrollment Form

STEP 5 - MEDICATION HISTORY

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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

STEP 6 - NEW PRESCRIPTION(S) INFORMATION

1. Send Prescriptions by Mail to:
   Homescrrips Pharmacy
   Attn: New Member Enrollment
   500 Kirts Blvd., Suite 300
   Troy, MI 48084

2. Ask Your Provider to Call or Fax Prescriptions to:
   Homescrrips Pharmacy
   Attn: New Member Enrollment
   500 Kirts Blvd., Suite 300 | Troy, MI 48084
   Phone: (888) 239-7690 | TTY: Please dial 711 OR
   Fax to: (877) 396-5970

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 Homescrrips. I authorize my provider to send my prescription(s) to Homescrrips, I authorize my provider to consult with a Homescrrips pharmacist regarding any medication related concerns, and 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.

Printed Name: ____________________________________________

Signature of Member of Legal Representative: ___________________________ Date: __________

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

Please email the completed, saved form to customerservice@homescrrips.com OR fax to (877) 396-5970.

Toll-free: 1-888-239-7690
TTY: Please dial 711 for phone relay assistance

Customer Service Hours:
M-F 8am - 8pm EST, Sat 10am - 2pm EST