New Member Enrollment Form

Please completely fill out this New Member Enrollment Form. You can submit the form by faxing it to (903) 735-4011 or mailing it to:
RxDirect, P.O. Box 2470, Texarkana, TX 75504-2470

PRIMARY MEMBER INFORMATION

Primary Member Name:	
Primary Member ID #:	Group #:
Insurance Company:	
Employer Name (if applicable):	

PATIENT INFORMATION

Patient Name:		
Date of Birth:	Driver's License #:	State:
SSN:	Phone #:	Cell #:
Email:	Gender (please circle): Male Female	
Physical Address:		
City:	State:	Zip Code:
Shipping Address:		
City:	State:	Zip Code:
Drug Allergies (Please List):		
Health Conditions: (Please List):		

SPOUSE INFORMATION

Name:		
Date of Birth:	Driver's License #:	State:
SSN:	Phone #:	Cell #:
Email:	Gender (please circle): Male Female	
Shipping Address:		
City:	State:	Zip Code:
Drug Allergies (Please List):		
Health Conditions: (Please List):		

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DEPENDENT INFORMATION

Name:

Date of Birth: | Driver's License #: | State:

SSN: | Phone #:

Relationship: | Gender (please circle): Male Female

Shipping Address:

City: | State: | Zip Code:

Drug Allergies (Please List):

Health Conditions: (Please List):

Name:

Date of Birth: | Driver's License #: | State:

SSN: | Phone #:

Relationship: | Gender (please circle): Male Female

Shipping Address:

City: | State: | Zip Code:

Drug Allergies (Please List):

Health Conditions: (Please List):

Name:

Date of Birth: | Driver's License #: | State:

SSN: | Phone #:

Relationship: | Gender (please circle): Male Female

Shipping Address:

City: | State: | Zip Code:

Drug Allergies (Please List):

Health Conditions: (Please List):

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DEPENDENT INFORMATION
(continued)

Name:		
Date of Birth:	Driver's License #:	State:
SSN:	Phone #:	
Relationship:	Gender (please circle): Male Female	
Shipping Address:		
City:	State:	Zip Code:
Drug Allergies (Please List):		
Health Conditions: (Please List):		

I understand that I must be a member of an active RxDirect participating health plan to obtain this service.	
Print Name of Applicant:	
Signature of Applicant:	Date: