



How to Register your Medical Information and Prescription Drug Order for Immediate Processing

1. CALL 1-866-448-1726

Tell the operator you are from the [Rensselaer County](#) and would like to Register.

Please have your Social Security number handy as the operator will ask you questions to ensure your prescription will be filled properly. Then ask your doctor to fax the completed Document 3, and your prescriptions for a 90 day supply with 3 repeats to 1-866-436-2876.

OR

2. FILL OUT FORMS and FAX

Visit www.canpharmbenefits.com

Click on the tab called "Member Log-in", a pop up window will appear asking for your Member ID and Password. Member ID is "[Rensselaer](#)" and Password is "[Rensselaer](#)"

Print off the forms

Make certain your employee name, your dependents names, and Social Security number is on each page. If they are not completed in full, your registration will NOT be accepted. The medical questionnaire form is designed to provide the pharmacy with a summary of your drug history for your safety.

Prescriptions from your specialists are acceptable.

Make sure you have all the pages together and ready to fax at once.

The following summary will help you:

Document #	Form Name
1	Patient Health and Medication Background
2	US Customs Statement for international drug purchases/Patient Authorization and Release
3	Rx form or <u>Doctor's own prescriptions</u>

Your Doctors Office can fax your documents directly to: 1-866-436-2876

IMPORTANT: The fax MUST be sent only from your physician's office.

It is against the law for us to accept prescriptions by fax from any other location.

You can also complete the forms, and mail your forms with the ORIGINAL prescription(s) to us at:

[CanPharm Benefits 14 William St. N., Chatham, ON N7M4L1](#)

Contact Customer Service if needed: 1-866-448-1726 (9am to 5pm M-F est)

Once your documents have been received by our Prescription Processing Department, your order will be immediately prepared for delivery. Under normal circumstances, your order will arrive within 2 weeks of the time that we receive your order.

If you do not want your prescription drugs shipped immediately, you must indicate this and state clearly when you would like them delivered.



**Document 1
COMPLETED BY EACH PATIENT
ORDERING PRESCRIPTIONS**

Patient Health and Medication Background

Group 0750

Employee SSN# _____

Employee Name: _____

First
Last
Middle Initial

Full Patient Name: Same as employee, or: _____

First
Last
Middle Initial

Date of Birth: _____ Relationship to Employee _____

Occupation: _____ Employer: _____

Mailing address: Street _____

Apt / Unit# _____ City: _____ State: _____ Zip: _____

Home Phone # _____ Work Phone # _____ E-mail: _____

Gender: Male Female Height _____ Weight _____ lbs

Has there been a change in weight of more than 10 pounds in the last year? Yes No

Explanation for weight change: _____

Current Medical Conditions: _____

Over-the-counter Medications/Herbal Remedies

IMPORTANT - DRUG ALLERGIES (or write NONE)

Prescription Medication List *(Please ensure that all fields below are entered completely)*

Drug Name	Strength	Reason for taking	HOW LONG USED?	# times/day	What to avoid	Doctor name
<i>ex: Lipitor</i>	<i>ex: 25mg</i>	<i>ex: Cholesterol</i>	<i>ex: 2 years</i>	<i>ex: twice daily</i>	<i>ex: grapefruit</i>	<i>ex: Dr. Smith</i>

If you have additional medications to enter, please use an additional Medication Record Form and check here
 I certify that the above information is complete and correct to the best of my knowledge and recollection.

Patient Signature: _____ Date: _____



Document 2
COMPLETED BY EACH PATIENT
ORDERING PRESCRIPTIONS

U.S. Customs Statement - International Drugs

U.S. Physician Name: _____

State License Number: _____

(from prescription)

Physician Address: _____

His or her original prescription is attached.

The undersigned hereby acknowledges, confirms and certifies that the enclosed medication(s) is (are) imported to the U.S.A. solely for personal use for a period not exceeding three (3) months.

Patient Name: _____

Address: _____

PATIENT Signature: X _____

Group 0750 Employee SSN# _____

Patients must provide a separate, signed statement for each prescribing physician.

U.S. Physician State License Number can be found on your original prescription.

CanPharm Benefits Ltd. Authorization and Release

Group Name: Rensselaer County, New York _____

Employee ID# _____

Patient Name: _____

No prescriptions will be filled without a signed and dated copy of this form.

- The Patient hereby authorizes (a) any of his or her primary physician, Canpharm Benefits Ltd. to release any and all information regarding the Patient's physical condition, including but not limited to all x-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to any other physician (the "referred physician") who may be required to review the Patient's health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication; (b) the referred physician to prescribe, if he or she deems it advisable and appropriate, a prescription medication; (c) the referred physician to release any and all information he or she may possess to any pharmacy outside of the United States for the purpose of having the Patient's prescription filled; (d) Canpharm Benefits Ltd., the primary physician, the referred physician and any such pharmacy to release any such information concerning the Patient to any person undertaking the adjudication and/or payment of any such prescription, and/or payment of any such prescription, and for any such person to provide reports in respect thereof containing any such information to any of Canpharm Benefits Ltd. and any such pharmacy; and (e) the Patient further authorizes Canpharm Benefits Ltd., the primary physician, the referred physician, and any such Canadian/International pharmacy to release any such personal information concerning the Patient to any person undertaking the adjudication and/or payment of any such prescription, and for any such person to provide reports in respect thereof containing any such personal information to Canpharm Benefits Ltd., and/or such Canadian/International pharmacy. It is agreed that Canpharm Benefits Ltd. may act as the Patient's agent for the purpose of assigning or transferring the Patient's prescription(s) to any licensed pharmacy it deems to be in the interest of the Patient.
- The Patient acknowledges that he or she wishes to obtain a prescription from a referred physician outside of the United States and accepts all of the risks inherent with the fact that such referred physician has not personally examined the Patient. The Patient understands and accepts that the referred physician will rely on the accuracy of the history, functional inquiry, and examination performed and provided by the Patient's primary physician in the United States. The Patient hereby authorizes the referred physician to contact the primary physician if necessary for clarification or confirmation of any details concerning the Patient's medical history or condition or the prescription issued by the Patient's primary physician.
- The Patient acknowledges having read and agreed to Canpharm Benefits Ltd. security policy re: transmission of information over the Internet. Canpharm Benefits Ltd. uses a secure server with 128-bit encryption and SSL (Secure Socket Layers) to ensure all Patient information is secure and private. Patient data is stored on secure media which is not stored online.
- The Patient acknowledges that prescription medication, once shipped, may not be returned for a refund or an exchange.

By signing this document the Patient confirms that he or she has read and understood these terms and that they are true and correct and the Patient agrees that the terms herein are binding on the Patient and the heirs, assigns, successors and personal representatives of the Patient and further understands that the released information will no longer be protected by federal privacy regulations.

I understand this authorization will start on the date signed below and expire in one (1) year.

PATIENT Signature: X _____ *Signing Parent or Guardian* (please print your name): _____

IMPORTANT!

Please photocopy this form if you need additional pages, or call Canpharm Benefits Ltd. (1-866-448-1726)

PLEASE FAX ALL FORMS ONLY FROM YOUR DOCTOR'S OFFICE TO 1-866-436-2876



Document 3
COMPLETED BY PHYSICIAN

Fax to: 1-866-436-2876
OR mail to: CanPharm Benefits Ltd.
14 William Street North
Chatham, Ontario (Canada) N7M 4L1



Group 0750

Employee SSN#

Patient name: _____

Shipping address: Same as member, or: _____

PHYSICIAN: Please complete the prescription below or attach your legible, printed and faxable prescription pad original.

	<u>Drug name</u>	<u>Strength</u>	<u>Frequency</u>	<u>Quantity</u>	<u># of Refills</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____

All prescriptions will be shipped immediately unless requested otherwise.
All prescriptions are issued for a period of 90 days plus 3 refills.
In order to avoid delays, please type or print legibly in black ink.

No generic substitution.

The patient has been on these medications for at least 90 days.

X _____
Prescribing Physician's Signature Date: _____

Physician's name: _____

Physician's address: _____

DEA #: _____ State License # _____

Physician's Phone: _____ Physician's Fax _____

FAX TO: 1-866-436-2876