Harness Health Pharmacy

Patient Enrollment Form

Harness Health Home Delivery Pharmacy offers a convenient way to get the medications you need – when and where you need them!

Step 1: Send us your information

To begin home delivery, complete this form in its entirety and return it by:

Mail –
Harness Health Pharmacy
7160 Industrial Row Drive, Suite 330
Mason, OH 45040

Or call – 866-775-5767

Fax – 513-557-7675

If you access this form online, you can complete the form by keying in your information. Print to add the Cardholder Signature and Teammate Signature, then return as directed.

Step 2: Ask your provider for a new prescription

Request new prescription(s) be sent to Harness Health Home Delivery Pharmacy by contacting your provider, either by phone or via any secure system that allows you to access portions of your medical records. Ask for a 90-day supply of a medication – with refills up to one year, if appropriate – for the lowest cost to you.

The provider can submit a prescription by:

E-Prescription – Harness Health – Home Delivery

Fax – 513-557-7675

Phone – 866-775-5767

If you have additional question or concerns, reach out to us directly! We are happy to assist with the enrollment process.

Step 3: Receive confirmation

After receipt, we'll call you to be sure we have everything we need to provide your pharmacy services.

Have Questions? Visit Our Website or Call Us!

To learn more about home delivery or for help from our Clinical Pharmacy team, call us at **866-775-5767** or visit our website at https://www.harnessrx.com. We look forward to helping you!
Our hours of operation are weekdays 8 a.m. -- 4:30 p.m. ET.

Associate Information

M / F

Full Name: _____

First *Middle* *Last* *Gender*

Address: _____

Street Address *Apartment/Unit #* *City* *State* *ZIP Code*

Birth Date:_____ Home Phone:_____ Cell Phone: _____

E-Mail Address:_____

For updates and notifications please enroll me in text message alerts: ☐ Yes ☐ No

Harness Health Home Delivery Pharmacy may use my email address to:

- notify me when a package has been shipped. ☐ Yes ☐ No
- sign me up for prescription copay savings cards on my behalf when available. ☐ Yes ☐ No

Medication and Food Allergies:_____

Patient	Prescriber Name	Prescriber Phone #	Drug Name and Dosage Strength	Patient will contact prescriber for prescription	Please contact my prescriber for this prescription
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
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				☐	☐
				☐	☐

Dependent Information

Name:_____ DOB:_____ Med. Allergies: _____

Preferred Phone: _____ Email: _____

Cell Phone ☐ Home Phone ☐ Other ☐

If cell phone number selected, please sign me up for text message notifications: Y ☐ N ☐

Please use my email address to:

- notify me when my package has been shipped & sign me up for prescription savings cards on my behalf when available. Y ☐ N ☐

Name:_____ DOB:_____ Med. Allergies:_____

Preferred Phone: _____ Email: _____

☐ Cell Phone ☐ Home Phone ☐ Other

If cell phone number selected, please sign me up for text message notifications: Y ☐ N ☐

Please use my email address to:

- notify me when a package has been shipped & sign me up for prescription copay savings cards on my behalf when available. Y ☐ N ☐

Name:_____ DOB:_____ Med. Allergies: _____

Preferred Phone: _____ Email: _____

☐ Cell Phone ☐ Home Phone ☐ Other

If cell phone number selected, please sign me up for text message notifications: Y ☐ N ☐

Please use my email address to:

- notify me when a package has been shipped & sign me up for prescription copay savings cards on my behalf when available. Y ☐ N ☐

Prescription Insurance Information

Primary Prescription Insurance

Name of insurance	Cardholder or Member Name	BIN #
MedImpact		003585

Rx Group Number	Rx PCN	Cardholder or Member Rx ID Number
	ASPROD1	

Secondary Prescription Insurance *(if applicable)*

Name of insurance	Cardholder or Member Name	BIN #

Rx Group Number	Rx PCN	Cardholder or Member Rx ID Number

Payment Information – *Please provide a credit card in addition to any Benefit Card you have.*

Cardholder Name

Cardholder Signature

Card Type	Account Number	Expiration Date
Benefit Card (HRA/ Health Care FSA Card)		
Credit Card (Visa, MC, Discover, Amex)		

Please Read and Sign *By signing the information below, I acknowledge:*

- Harness Health Pharmacy will substitute generic formulations unless I or my prescriber indicates otherwise in advance.
- I am providing Harness Health Pharmacy with payment information that will be used to process any copayment or coinsurance. I authorize this information to be retained for future payments. Harness Health Pharmacy will use it to process copayment or coinsurance when I request refills.
- I understand that I may contact Harness Health Pharmacy to speak with a pharmacist at **866-775-5767**.

Patient Signature _____ Date _____