

Patient Enrollment Form

Please complete and fax this form to EagleCAN 1-833-324-5346.
 Both you and your patient must sign on page 2.
 For assistance or additional information, call 1-833-324-5322 Monday – Friday.



By submitting this form, I am requesting support services on behalf of the patient indicated below. Services include benefits verification and prior authorization support.

REQUIRED FIELD*

PATIENT INFORMATION			
First Name*		Middle Initial	Last Name*
DOB (MM/DD/YYYY)*		Gender	Email
Address*		City*	State* Zip*
Primary Phone Number*		Secondary Phone Number	
Okay to Contact Patient for Additional Information?		U.S. Residency Status	
Alternate Contact Name		Relationship	Phone Number
INSURANCE INFORMATION			
Check if patient does not have insurance		Check if patient has secondary insurance	
Primary Insurance Name*		Insurance Phone*	
Policy #*		Group #*	
Policyholder Name*		Relationship to Patient	
Secondary Insurance Name*		Insurance Phone*	
Policy #*		Group #*	
Policyholder Name*		Relationship to Patient	
PRESCRIBER INFORMATION			
First Name*		Middle Initial	Last Name*
Tax ID #	NPI #*		Group NPI #
Payer Specific Provider #			
Practice Name*			
Address*		City*	State* Zip*
Practice Phone Number*		Practice Fax Number*	Practice Email
Practice Contact Name*			

Hours of Operation:
 Monday through Friday
 9 AM to 8 PM EST

Address:
 EagleCAN
 P.O. Box 220126
 Charlotte, NC 28222

Phone: 1-833-324-5322
Fax: 1-833-324-5346

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CLINICAL INFORMATION		
Primary Diagnosis*	Secondary Diagnosis	Tertiary Diagnosis
Eagle Product Prescribed*		
Previous Therapies, if any		
Concurrent Therapies, if any		
Site of Care*		
ATTESTATIONS AND SIGNATURES		
Prescriber Attestation: I confirm that I have prescribed the Eagle product identified above as an appropriate treatment for this Patient. I have not been offered or promised anything of value by Eagle in exchange for writing this prescription. I confirm that the above provided information is true and correct to the best of my knowledge.		
Prescriber Signature*	Date*	
Patient Attestation: I confirm that the above provided information is true and correct to the best of my knowledge and I request the support provided by the EAGLE CAN program as described above. I understand I may revoke this request at any time by phoning the EagleCAN program at 1-833-324-5322.		
Patient Signature*	Date*	

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