AccidentMeds

CARD ACTIVATION REQUEST FORM

FAX **THIS FORM** AND **COPY OF PATIENT ACCIDENTMEDS CARD** TO **(866) 446-3615**

~ALL FIELDS ARE MANDATORY~

IMPORTANT: CARD ID #_____IMPORTANT: ACTIVATION CODE_____

Do not issue patient a new AccidentMeds card if they have misplaced a previous card. Replacement cards may be obtained by emailing info@AccidentMeds.com; please include your name and phone number.

DOCTOR INFORMATION

Physician's First Name	Physician's Last Name	Office Phone
_____	_____	(_____)_____

ATTORNEY ADDRESS

Attorney's First Name	Attorney's Last Name	Office Phone
_____	_____	(_____)_____

Firm Name	Fax Number	THIS FORM WILL BE FAXED TO THIS NUMBER
_____	(_____)_____	

Attorney Address	City	State	Zip
_____	_____	_____	_____

PATIENT INFORMATION

Patient's First Name	Patient's Last Name	Phone Number
_____	_____	(_____)_____

Date of Birth	Date of Injury	Social Security
_____/_____/_____	_____/_____/_____	_____-_____-_____

Patient Address	City	State	Zip
_____	_____	_____	_____

Acknowledgement of Lien

1. I am the person listed on this AccidentMeds card. I have retained an attorney to pursue my interests in a personal injury claim.
2. I do not have the funds or insurance coverage, nor do I qualify for any Government-related program, which would allow me to obtain the prescription medications ordered by my doctor as a result of this accident.
3. I request that the charges for these prescription medications be held on a lien with my attorney to be included in the settlement of my claim. I understand that regardless of the outcome of my claim, I am responsible for the charges I will incur.
4. I understand the medication charges may vary by pharmacy, and I may at any time discontinue use of this card and/or identify another pharmacy solution.
5. I authorize Pharmacy provider to furnish any medical or billing records to my attorney.
6. LIEN ACCEPTANCE: I understand that this document is a summary of the complete Lien document that is available to me at any time at www.AccidentMeds.com/Lien. My use of this card to acquire prescription medications at a pharmacy shall serve as my acceptance of the lien terms.

FAX COMPLETED REQUEST FORM TO:

AccidentMeds

(866) 466-3615

I am requesting activation of this pharmacy card. I will use this card for accident related medications that have been prescribed by my doctor and consent to the charges for the medications to be included on a lien with my personal injury case. I agree to the terms on the this form and I authorize AccidentMeds/Key health to contact my attorney

Patient Signature_____

Date: _____

AccidentMeds/Key Health will obtain ATTORNEY SIGNATURE

Attorney Signature_____

Date:_____