

**INELIGIBLE PERSON
PHARMACY ENROLLMENT FORM**

DATE: ____/____/____

TO: **Northern Arizona Regional Behavioral Health Authority**
FAX: (928) 913-0399 ATTN: MIS Specialists Unit

FROM: Name: _____ Clinic/Site: _____

DIRECTIONS: *Use this form to add an ineligible (non TXIX/TXXI) member into the Pharmacy System so s/he can receive NARBHA subsidized medication services*

Member Last Name	
Member First Name	
Member ID	
Date of Birth	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #	
Population	<input type="checkbox"/> Child <input type="checkbox"/> Mental Health/Alcohol/ Drug <input type="checkbox"/> SMI
Eligibility Start Date	
Eligibility End Date (Maximum- 3 months)	

CLINIC AUTHORIZATION	
Print Name: _____	
Signature: _____	
Title: _____	Date: _____