

PM FORM 3.16.6

NARBHA PHARMACY/MEDICATION
PRE-ENROLLMENT REQUEST

DATE: ____/____/____

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

FROM: Name: _____ Clinic/Site: _____

DIRECTIONS: Use this form to enroll members into the Pharmacy System if they need to receive medication services BEFORE S/HE IS FULLY ENROLLED WITH NARBHA.

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 <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> SMI
Intake Date	
Title XIX/XXI	<input type="checkbox"/> Yes <input type="checkbox"/> No (Must attach AHCCCS printout)
Hometown	

NOTE: If a brand name med. (generic available) is needed, complete and fax a MEDICATION/LAB PHARMACY EDIT NOTIFICATION REQUEST FORM.