



Enrollment Application

Instructions: The following information is necessary to process application.

To avoid delays in the approval process, please ensure all requested information is provided. Once completed **FAX to (866) 856-8905**. If you are an attorney, FAX and then call (877) 6Rx-Hurt, ext. 205 for a case status.

Indicate Your Selection - Please Circle one of the following: Only First Fill, First Fill plus Refills, Only Refills

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Date of Injury: _____ Gender (Circle Above): **M** **F**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Liability Insurance: _____ Defendant's Insurance: _____

\$ _____ \$ _____ \$ _____
Policy Limits: Total Outstanding Medical Cost to Date: Estimated Additional Medical Costs:

Were you employed? _____ No _____ Yes Has Liability been established? _____ No _____ Yes

Do you have any type of health insurance? Yes / No If yes, describe: _____

Healthcare Provider Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Contact Name: _____ Treatment/Condition: _____

Attorney Information:

Attorney Name: _____ Law Firm Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Cell Phone: _____ Email: _____

Perferred Contact Name: _____ Email _____ Phone: _____

Type of Case: Case #: _____

Motor Vehicle Accident: _____ Slip/Fall: _____ Other: _____

If Other, please explain: _____

Case Status: _____

Comments: _____

Applicant Release

I, the applicant, am hereby authorizing DrugSource, Inc., their agents, lending institutions and underwriters to review all the confidential information of my case, and underwrite my case on an exclusive basis.

Print Name: _____ Date: _____

Signature: _____