Generics+ Enrollment Form

PATIENT INFORMATION

Patient Name _____
Last First M.I.

Date of Birth _____ Sex: M / F (please circle)

Address _____ City _____ State ___ Zip _____

Daytime Phone # (___) _____ Home Phone # (___) _____

Drug Allergies: ☐ None ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Aspirin ☐ Other_____

Bring this completed form along with your new, refill or transfer prescription to your local Kmart Pharmacy and start saving today!

Attn: Kmart Pharmacist – Please submit claims under PDX Carrier Code: RMP