



Rcopia Provider Registration

Date: _____

Practice Name: _____

Provider Name: _____

Title (please check one): MD DO PA CNP Resident RN

Address: _____

Specialty: _____

DEA Number: _____

Medical License #: _____

State of Valid License: _____

Exp Date: ____/____/____

Email Address: _____

Office Phone: _____

Fax Number: _____

Please provide the contact information for the individual responsible for assisting us in setting up training and data extractions at your office location.

Name: _____

Phone: _____

Email: _____

Back Line (Optional): _____

Please select ONE free PDA:

HP IPAQ (PocketPC)

TungstenTX (PalmOS)

None

By signing below, the person named above (the "provider") acknowledges that he/she:

- is a licensed medical practitioner with the legal authority to write prescriptions in the state(s) in which he/she practices medicine;
- agrees that Blue Cross Blue Shield of Delaware is paying the first year's subscription fee for the *DrFirst Rcopia* service on behalf of the provider and that, after the first year of use, if he/she wants to continue to use the service, he/she will be responsible for the annual subscription fee;
- understands that Blue Cross Blue Shield of Delaware is making no representations or warranties regarding the *DrFirst Rcopia* service and that the agreement for the use of the service is solely between the provider and *DrFirst* and is subject to the provider's acceptance of the *DrFirst Rcopia Terms of Use* and the business associate agreement (available from *DrFirst*);
- will use the *Rcopia* service for electronic prescribing; and
- if he/she does not write at least 50 prescriptions each month for the first three months via the *DrFirst Rcopia* system after he/she begins using the service, *DrFirst* shall have the right to retrieve any hardware provided pursuant to this agreement, unless the provider chooses to pay for such hardware.

Provider Signature and "Brand Medically Necessary": Please provide your signature in the box below so that we can include it on your prescriptions, when a signature is required. Please be sure to fill the entire box with your signature, but do not allow it to touch the sides. In addition, if you choose to mark a prescription "Dispense as Written," Delaware law requires that you write "Brand Medically Necessary" on the prescription. Please write "Brand Medically Necessary" in the second box below so that we can add this to your prescription if necessary.

Signature - PLEASE DO NOT SIGN OUTSIDE THE LINES!

Brand Medically Necessary - PLEASE DO NOT SIGN OUTSIDE THE LINES!

3206 Tower Oaks Blvd., Suite 310 • Rockville, MD 20852
888.271.9898 (phone) • 240.536.9145 (fax) • www.DrFirst.com