Mail Service Order Form

Mail this form to:

Member ID # (if not shown or if different from above)

Instructions:
Please use **blue or black ink** and **print in capital letters.** Fill in **both sides** of this form.
New prescriptions - Mail your new prescriptions with this form. Number of **new** prescriptions:

Refills - The ovals you fill in for section B tell us which refills you need. Number of **refill** prescriptions:

Please fold here

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

LAST NAME | FIRST NAME | M | Suffix

STREET ADDRESS | APT #

○ **Use shipping address for this order only.**

CITY | ST | ZIP —

Daytime phone # - -

Evening phone # - -

B Refills. Fill in the oval for each refill you want to order. Like this ●

C Refills not listed below. See Invoice for information on prescriptions in your order that are not listed below. To order a refill not listed below, write the prescription number(s) here:

1) _____ 2) _____ 3) _____

○

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*Actual cost may change based on your prescription plan. We may package all of these prescriptions together unless you tell us not to. All claims for prescriptions sent in with this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

D **Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

First person with a refill or new prescription. ○ Spanish forms and labels

LAST NAME | FIRST NAME | M | Suffix (JR,SR)

NICKNAME | Gender: ○ M ○ F | Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other: _____

Second person with a refill or new prescription. ○ Spanish forms and labels

LAST NAME | FIRST NAME | M | Suffix (JR,SR)

NICKNAME | Gender: ○ M ○ F | Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other: _____

Please fold here

E **Special instructions:** _____

F **How would you like to pay for this order?** (If your copay is $0, you do not need to provide payment information.)

○ **Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

○ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

○ Use your card on file.

○ Use a new card or update your card's expiration date.

CARD NUMBER | Exp. Date MMYY

Credit card holder signature/Date

○ **Check or money order.** Amount: $ ____ . ____

- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for balance due and future orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

○ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

I authorize my benefit manager to bill my credit card. I understand that it will be billed for my copayments, coinsurance, deductible, and special shipping costs.

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

○ **2nd business day ($17)**

○ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)