

Catalyst Mail MAIL-ORDER FORM



1 Member information: Please verify or provide member information below.

Member ID: _____

Group: _____

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: _____@_____.

☐ New shipping address: _____

Catalyst Mail will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.

Daytime phone: _____

Evening phone: _____

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Catalyst Mail**, and write your member ID number on the front. You can enroll for e-check payments and price medications at **www.catalystrx.com**, or call **1 866 814-7105**.

Number of prescriptions sent with this order:

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:

☐ Visa ☐ MC ☐ Discover ☐ AmEx ☐ Diners

Expiration date

M M Y Y

X

Cardholder signature

Credit card number

☐ I authorize **Catalyst Mail** to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment (\$15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at 1 866 814-7105. To verify Medicare Part B prescription coverage, call Medicare at 1 800 MEDICARE (1 800 633-4227).

Catalyst Mail will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at **www.catalystrx.com** or call Member Services at 1 866 814-7105. Member Services is available from 7:00 a.m. to 9:00 p.m., eastern time, Monday through Friday and from 8:00 a.m. to 6:30 p.m., eastern time, Saturday and Sunday. TTY/TDD users should call 1 866 830-3726.

Federal law prohibits the return of dispensed controlled substances.

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the **Catalyst Mail** address shows through the window. Do not use staples or paper clips.

CATALYST MAIL
PO BOX 99
AVON LAKE, OH 44012-9903



Patient
name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date
of birth:

Month					Day					Year									

SECTION 3: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to **all** that apply.

<input type="radio"/>	Allergies, hay fever (allergic rhinitis)	<input type="radio"/>	Heart failure (CHF)
<input type="radio"/>	Arthritis	<input type="radio"/>	Hemophilia and hemophilia-like conditions
<input type="radio"/>	Asthma	<input type="radio"/>	High blood pressure (hypertension)
<input type="radio"/>	Bladder control problem (urinary incontinence)	<input type="radio"/>	High blood sugar (diabetes)
<input type="radio"/>	Brittle bones (osteoporosis)	<input type="radio"/>	High cholesterol (hypercholesterolemia)
<input type="radio"/>	Chest pain (angina)	<input type="radio"/>	Inflammatory bowel disease
<input type="radio"/>	Crohn's disease	<input type="radio"/>	Migraine headache
<input type="radio"/>	Depression	<input type="radio"/>	Overactive thyroid (hyperthyroid)
<input type="radio"/>	Emphysema (COPD, chronic bronchitis)	<input type="radio"/>	Peptic, stomach, or duodenal ulcer
<input type="radio"/>	Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	Poor circulation in the legs (peripheral vascular disease)
<input type="radio"/>	Gastric reflux, heartburn, or esophagitis (GERD)	<input type="radio"/>	Seizures (epilepsy)
<input type="radio"/>	Glaucoma	<input type="radio"/>	Stroke (TIA)
<input type="radio"/>	Heart attack (myocardial infarction)	<input type="radio"/>	Underactive thyroid (hypothyroid)

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SECTION 4: Your nonprescription medications

Fill in the oval completely for each **nonprescription medication** that you are currently taking on a regular basis.

<input type="radio"/>	Advil®/ibuprofen	<input type="radio"/>	Prilosec OTC®/omeprazole
<input type="radio"/>	Aleve®/naproxen	<input type="radio"/>	Sominex®, Nytol®/diphenhydramine
<input type="radio"/>	Bayer®/aspirin	<input type="radio"/>	Tagamet®/cimetidine
<input type="radio"/>	Benadryl®/diphenhydramine	<input type="radio"/>	Tylenol®/acetaminophen
<input type="radio"/>	Orudis KT®/ketoprofen	<input type="radio"/>	Zantac®/ranitidine
<input type="radio"/>	Pepcid AC®/famotidine		

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Additional health information

If you have any other medication allergies, medical conditions, or nonprescription medications not listed above, please call **1 866 814-7105**. You may call from 7:00 a.m. to 9:00 p.m., eastern time, Monday through Friday, and from 8:00 a.m. to 6:30 p.m., eastern time, Saturday and Sunday (except Thanksgiving and Christmas). TTY/TDD users should call 1 866 830-3726.

Did you complete both sides?

Thank you very much.