ENVISIONMAIL

MAIL SERVICE
PRESCRIPTION PROGRAM

EnvisionMail is a mail order pharmacy for its members. EnvisionMail offers home delivery of monthly medications with no shipping or handling fees for standard delivery. You mail receive up to a 90-day supply of most medications delivered right to your door before you are out of medication.

To obtain your mail order prescriptions from EnvisionMail, you will need to create an account. You can create an account before you are ready to order. To create an account an enroll in EnvisionMail, you must do one of the following:

- Complete the enrollment form
- Mail to EnvisionMail at **7835 Freedom Ave NW, North Canon OH 44720**; or
- Enroll online at **envisionpharmacies.com**; or
- Enroll via telephone at **1-866-909-5170** or **TTY 711** (Monday–Friday 8:00am–10:00pm and Saturday 8:30am–4:30pm)

MEMBER INFORMATION

Last Name: _____ First Name _____ Middle Initial: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Group Number: _____ Member Identification Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F Email: _____

Drug Allergies: ☐ No Known Allergies ☐ Erythromycin ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Sulfa
☐ Other: _____

PAYMENT INFORMATION

PAYMENT METHODS: *Select from one of our available payment methods below.*

CHECK/MONEY ORDER: ☐ Check ☐ Money Order **CREDIT CARD:** ☐ VISA ☐ MasterCard ☐ Discover ☐ Amex

Print name as it appears on card: _____

Card Number: Expiration Date: 00 / 0000

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_____ Please initial this line to authorize EnvisionMail to charge your credit card to pay for each pharmacy order. Charge dates and amounts will vary with each order.

Signature: _____

If paying by check or money order, mail payment to EnvisionMail.

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Mail your original prescriptions with this Enrollment Form or have your doctor fax them directly to **1-866-909-5171**.

Once we begin to fill your prescriptions you may order refills 24 hours a day, seven days a week by calling **1-866-909-5170** or **TTY 711** (Monday–Friday 8:00am–10:00pm and Saturday 8:30am–4:30pm) to speak with a representative or our automated system. You may also order refills online at **envisionpharmacies.com**.

SPECIAL HANDLING

_____ Please initial this line if you do **not** want child-proof caps mailed to your household. Snap caps or easy-off lids will be sent with your medications if this line is initialed.

Generics: EnvisionMail will automatically dispense the generic drug unless your prescriber writes "D A W" (dispense as written) on the prescription and the brand name drug is medically necessary. Brand name drugs typically require you to pay a higher co-payment.

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time.

DESIGNATION OF PERSONAL REPRESENTATIVE

I, (Name)_____ (Date of Birth) ____/____/_____ hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.

_____ _____

Print Name of Personal Representative) Relationship of Personal Representative to Member

_____

(Phone Number of Personal Representative)

PLEASE CHECK ONLY ONE BELOW:

☐ The person named above is to be given all of the privileges that would be given to me with respect to my protected health information.

OR

☐ The person named above is acting as my designated personal representative **only** for the following functions:

I understand that I may cancel this designation at any time by contacting EnvisionMail at **1-866-909-5170** or **TTY 711** (Monday–Friday 8:00am–10:00pm and Saturday 8:30am–4:30pm). I understand any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Signature _____ Date _____