PRESCRIPTION MAIL ORDER FORM

Please complete all portions of this form by printing in **ALL CAPITAL LETTERS** using **BLACK INK**.

Questions about your pharmacy benefit? Call the Customer Service number that was provided to you. If there are more than 3 Family Members, write the information on a separate piece of paper.

1. PERSONAL INFORMATION

MEMBER

Cardholder ID Number (If you do not know your ID, use your Social Security Number)

NOTE: ID Number may not fill all boxes.

Member First Name | **M.I.** | **Member Last Name**

Birth Date M M - D D - Y Y Y Y | **Gender**

Physician Last Name | **Physician Phone #** - -

FOLD HERE

Family Member 1

Family Member 1 First Name | **M.I.** | **Family Member 1 Last Name**

Birth Date M M - D D - Y Y Y Y | **Gender**

Physician Last Name | **Physician Phone #** - -

Family Member 2

Family Member 2 First Name | **M.I.** | **Family Member 2 Last Name**

Birth Date M M - D D - Y Y Y Y | **Gender**

Physician Last Name | **Physician Phone #** - -

Family Member 3

Family Member 3 First Name | **M.I.** | **Family Member 3 Last Name**

Birth Date M M - D D - Y Y Y Y | **Gender**

Physician Last Name | **Physician Phone #** - -

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DRUG ALLERGY CONDITIONS

INSTRUCTIONS FOR COMPLETING THE DRUG ALLERGY CONDITIONS:

For each covered family member, please mark an "X" in the appropriate box for allergies.

	Member	Family Member 1	Family Member 2	Family Member 3
(00) No known allergies				
(01) Penicillins (Ampicillin, Amoxicillin, Others) and Cephalosporins (Keflex, Velosef, Suprax, Cefzil, Others)				
(03) Aspirin and non-steroidal pain relievers (Vioxx, Ibuprofen, Naproxen, Celebrex®, Others)				
(04) Codeine				
(15) Sulfa Type Drugs (Celebrex®, Glyburide®, Glucotrol®, Micronase®, Others)				

If not listed above, write other health conditions and drug allergies in the space provided.

2. SHIPPING INFORMATION

Please provide us with a street address to allow delivery of your order. Certain medications cannot be delivered to a P.O. Box.

First Name **Middle Initial**

Last Name

Address

City

State **ZIP or Postal Code** -

Phone # - -

FOLD HERE

3. PAYMENT INFORMATION

Standard delivery of your order is **FREE**. Your order will arrive within 14 days from the date we receive your order.

Please include payment with your order. **DO NOT SEND CASH**. To calculate your payment, please refer to your prescription drug-benefit plan materials for your prescription copay.

Credit Card # **Expiration Date** M M - Y Y

NOTE: All future orders will be charged to this credit card, unless payment (check) accompanies the order.

Cardholder Name

x Authorized Signature

Please print name as it appears on credit card

Check/Money Order

Amount Enclosed $.

FOLD HERE

4. SIGNATURE INFORMATION

Please read and sign the following statement:

I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment, or health care operations.

x Signature Required

If applicable, please sign the following statements.

I request that this and future orders be shipped "Signature Required". I understand there will be an additional charge for this service.

x Authorized Signature

I would like my prescriptions dispensed with **NON-CHILD** resistant caps.

x Authorized Signature

REVIEW YOUR PRESCRIPTION

We will dispense FDA approved generic medications when allowed by your physician, subject to terms outlined in your plan.

- **Check to see if the patient name is clearly written on the prescription.** If not, print the patient's full name, address, phone number and date of birth on the back of the prescription.
- **Check to see if the physician's signature is legible.** If not, please circle the physician's preprinted name on the prescription, or print the name of the physician on the back of the prescription.
- **Check to see if the physician's phone number is printed on the prescription.** If not, please print the physician's phone number, including area code, on the back of the prescription.

INSTRUCTIONS FOR COMPLETING THIS FORM

- Please complete all portions of this form by printing in **ALL CAPITAL LETTERS** using **BLACK INK**.
- Make sure you have **completed** the Drug Allergy Conditions section. This enables our pharmacists to review your patient record prior to filling prescriptions.
- Fold the completed form and place it in the pre-addressed envelope provided.
- Place your prescriptions in the envelope with the form.
- Include your check or money order (if not paying with a credit card).