medco

MEDCO BY 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

_____

_____

_____

(Medco 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 Fill out a separate section for each person requesting a prescription fill. If he/she has more than one prescription from the same doctor, complete just one section but include all prescriptions in the envelope provided. If a person has prescriptions from more than one doctor, complete a new section for each doctor and include all prescriptions. Additional patient/doctor space is provided on the next page.

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date(MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐ Sex ❑M ❑F

Patient's relationship to member ❑Self ❑Spouse ❑Dependent ❑Domestic partner

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ 1st initial ☐ Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date(MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐ Sex ❑M ❑F

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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 Medco Health Solutions, Inc.,** and write your member ID number on the front. To enroll for e-check payments, complete and return the e-check form (fifth page printed) with your order.

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

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date ☐☐ ☐☐ M M Y Y

X _____ Cardholder signature

❑I authorize Medco to charge this card for all orders from any person in this membership.

❑Rush this shipment ($15, subject to change). **Note:** This will **not** rush prescription processing. (Street address required; P.O. box not allowed.)

Mailing instructions are provided on the next page

Patient/doctor Information continued

First name | Last name

Birth date(MM/DD/YYYY) Sex ❑M ❑F

Patient's relationship to member ❑Self ❑Spouse ❑Dependent ❑Domestic partner

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 ❑Domestic partner

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, plus refills for up to 1 year, if appropriate (not a 30-day supply, plus refills). Also, ask your doctor or pharmacist about safe, effective and less expensive generic drugs.

Complete the health, Allergy and Medication Questionaire.

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.To verify Medicare Part B prescription coverage, call Medicare at 1 800 MEDICARE (1 800 633-4227).

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

❑ Pensylvania and Texas laws permits pharmacists to submit a less expensive generically equivalent drug 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 "product."** 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.medco.com** or call the number on your member ID card. TTY/TTD user should call 1 800 759-1089.

Mailing instructions
Using a business-size envelope, send the following items to the address shown on the right:

Do not use staples or paper clips.

- Your prescriptions or refill slips
- Order form
- Health, Allergy & Medication Questionnaire
- Your payment
- E-check enrollment form (optional)

Medco Health Solutions of Fairfield
P.O. Box 747000
Cincinnati, OH 45274-7000

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