FOLD BACK HERE

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Medco By Mail Order Form

For Refills

To order by phone: Call **1 800 4REFILL** (**1 800 473-3455**) to use the automated refill system. Have your Subscriber number and your refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For New Prescriptions

Fill out one line of the Patient Information section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number. Be sure your prescription is written for a 90-day supply with refills.

For All Mail Orders

Place all prescriptions and refill slips together with this completed order form and Health, Allergy and Medication Questionnaire along with your co-payment in an envelope addressed to:

Medco
PO Box 747000
Cincinnati, OH 45274-7000

If You Need Additional Help

Find information regarding medications, pricing and lower cost alternatives online (use the member Web site on your ID card). Or call Customer Care at the number on your ID card.

See the back of this form for additional instructions.

Customer Information

RxGrp #: _____ ***Subscriber #:*** _____
(located under the logo on your ID card)

Name: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Evening telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Shipping address if different from your mailing address
Check if ☐ Temporary ☐ Permanent

_____

_____

_____

Patient Information—**Complete one line for each new prescription** *(Do not complete for refills)*

Patient name and Medicare B number (if applicable)	Patient's relation to plan subscriber *(fill in one)*	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1	Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
2	Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
3	Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No

Order Information

Total number of medications in this order
(including all refills and new medications) ☐

Subtotal of this order $☐☐☐.☐☐

Optional expedited shipping
$14.00 per order (subject to change) ☐☐.☐☐

Total enclosed
(do not send cash) $☐☐☐.☐☐

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail order co-payment regardless of the days supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with 3 refills.

Paying by Credit Card? ☐Visa ☐MC ☐Disc/NOVUS ☐AmEx ☐Diners

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
CREDIT CARD NUMBER

M ☐☐ Y ☐☐ **X** _____
EXPIRATION DATE CARDHOLDER SIGNATURE

☐ **Check here to have all orders billed to your credit card.**
By doing so, you authorize Medco to keep your card number on file and bill future orders and any outstanding balances directly to your credit card. To enroll by phone, please call **1 800 948-8779**.

Paying by check? Write your Subscriber number on your check or money order made payable to Medco Health Solutions, Inc.

MEDCO
PO BOX 747000
CINCINNATI OH 45274-7000

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Please take a minute to make sure…

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your Subscriber number on any check or money order.**
- **You have filled out the Health, Allergy, and Medication Questionnaire. This information will help Medco better serve your prescription medication needs.**
- **Your prescription is written for a 90-day supply with refills.**

Medication delivery

Your medication will be delivered to you within 7 to 11 days after you mail your order.

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered to your area. This option must be chosen when you make the order, and cannot be applied after an order is already processed.

Additional instructions

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all mail order pharmacy orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If you do, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance is paid.

You can call **1 800 948-8779** anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Ohio law allows a less expensive, generically equivalent medication to be substituted for certain brand-name medications unless you direct or your doctor directs otherwise.

To all Medicare beneficiaries whose private health plan has elected to be billed primary for Medicare Part B covered medications:

By choosing to use Medco's mail order pharmacy to fill your prescription, you are choosing to use the prescription medication coverage provided by your group health plan. Medco will process your prescription under your group health plan coverage, independent of the Medicare program, and no claim will be submitted to Medicare. If you believe that Medicare may also provide coverage and would like Medicare to pay for your prescription, you should go to a Medicare-participating pharmacy in your area. For a list of convenient Medicare-participating pharmacies, please call your local Medicare carrier or **1-800-MEDICARE**. If you have any questions about the difference in coverage between your group health plan coverage and Medicare, please call the number on your ID card.

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Health, Allergy & Medication Questionnaire

medco®

Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each family member enrolled in your pharmacy benefit plan.
- If you need additional forms you may call your Customer Care representative at the toll-free number listed on your ID card.
- **Return this questionnaire with your prescription or refill order form.**

SECTION 1 **SUBSCRIBER IDENTIFICATION AND CONTACT**

Group Number **Subscriber Number** **Daytime Telephone Number**

Primary Subscriber: First Name **M.I.** **Last Name**

Street Address/Apt. No. **City** **State** **Zip**

SECTION 2 **DRUG ALLERGY CONDITIONS**

For each family member enrolled in the program, include his/her name, date of birth and gender. For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If you are allergic to a medication that is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ● Please use blue or black ink.

	Enrollee	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name: Add last name if different than enrollee					
Date of Birth: MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillins/cephalosporins (e.g. ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g. Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	○	○	○	○	○
Aspirin (salicylates)	○	○	○	○	○
Sulfa medications	○	○	○	○	○
Iodine	○	○	○	○	○
Print other medication allergies not listed above in the space provided. Example: *morphine*					

Continue on the other side to tell us about any medical conditions. ☞

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SECTION 3 **MEDICAL CONDITIONS**

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said ***that particular family member*** has the condition.

First Name:	Enrollee	Spouse	Dependent	Dependent	Dependent
Congestive heart failure	○	○	○	○	○
High blood pressure	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine headache	○	○	○	○	○
Print other medical conditions not listed above in the space provided. Example: *glaucoma*					

Did you complete both sides?

Please return the questionnaire with your prescription or refill order form.

Thank You