

# Medco By Mail ORDER FORM



## 1 Customer information: Please verify or provide customer information below.

Subscriber #: \_\_\_\_\_

Rx Grp #: \_\_\_\_\_  
(located under the logo on your ID card)

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Daytime phone:

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 subscriber until another shipping address is provided by any person in this plan.)

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 one envelope.

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M  F

Patient's relationship to subscriber

 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 subscriber

 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 **Medco Health Solutions, Inc.**, and write your subscriber ID number on the front. You can enroll for e-check payments and price medications by calling **1 800 948-8779**.

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

Cardholder signature

Credit card number

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

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 subscriber

 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 subscriber

 Self  Spouse  Dependent

Doctor's last name

1st initial

Doctor's phone number

## Important reminders and other information

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.

**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 pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Customer Care number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1 800 MEDICARE (1 800 633-4227).

**Automatic generic equivalent substitution** of certain brand-name medications is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want** the generic medication. This applies only to the prescription medication(s) on this order.

Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your doctor direct otherwise. **Check the box if you do not wish a less expensive brand or generic medication "product."** Please note that this applies only to new prescriptions and to any future refills of that prescription.

**For additional information** or help, call the Customer Care number on your ID card. TTY/TDD users should call 1 800 759-1089.

**Mailing instructions:** Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD  
P.O. BOX 747000  
CINCINNATI OH 45274-7000





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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack or angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis or emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies, runny nose, hay fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood sugar (diabetes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peptic, stomach, or duodenal ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastric reflux, heartburn, or esophagitis (GERD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High pressure in the eyes (glaucoma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor circulation in the legs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble with blood not clotting properly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Print other medical conditions not listed above in the space provided. Example: <i>glaucoma</i>					

Did you complete both sides?

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

Thank You