

# Medco By Mail ORDER FORM

medco®



## 1 Member information: Please verify or provide member information below.

Member ID: \_\_\_\_\_

Group: CCIMED1

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: 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 the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex  
 M  F

Patient's relationship to member  
 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 member  
 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 member ID number on the front. You can enroll for e-check payments and price medications at **www.medco.com**, or call **1 800 820-9726**.

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

\_\_\_\_\_  
Cardholder signature

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

Rush the mailing of this shipment (\$14, 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 member

 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 member

 Self  Spouse  Dependent

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 & 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 prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at 1 800 820-9726. 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 drugs 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 less expensive,** generic drug. This applies only to the prescription drug(s) on this order.

Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent drug for a brand name drug unless you or your physician direct 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 future refills of that prescription.

**For additional information** or help, visit us at **www.medco.com** or call Member Services at 1 800 820-9726. TTY/TDD users should call 1 800 759-1089.

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the Medco address shows through the window. Do not use staples or paper clips.

**MEDCO HEALTH SOLUTIONS OF FAIRFIELD  
PO BOX 747000  
CINCINNATI OH 45274-7000**



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