

# MEDCO BY MAIL ORDER FORM



## 1 Member information

Please verify or provide member information below.

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

Group: \_\_\_\_\_

Date of Birth:         Gender:  M  F  
M M D D Y Y Y Y

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

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

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

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

City, State, ZIP: \_\_\_\_\_

Daytime phone:

Please send me e-mail notices about the status of the enclosed prescription(s) and online orders 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.)

Evening phone:

## 2 Member/Doctor information

If you have more than one prescription from the same doctor, complete just one section but include all prescriptions in the envelope provided. If you have prescriptions from more than one doctor, complete a new section for each doctor and include all prescriptions.

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

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

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

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

## 3 Complete your order

You can pay by 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.

Number of prescriptions sent with this order:

Payment options:  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 membership.

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

## 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 the typical 30-day supply, plus refills).

**Complete** the Member/Doctor information section.

**Be sure** you have filled out the Health, Allergy & Medication Questionnaire.

### Unpaid balances

If your plan limits the balance that you can carry on your account and you exceed that limit with this order, payment must be included. To price a medication, visit us online at [www.medco.com/medd](http://www.medco.com/medd) and click "Price a medication." To avoid processing delays, provide a credit card number in the "Complete your order" section on side 1.

### Generic substitution

Texas, Florida, and Ohio laws allow a generic equivalent drug to be substituted for certain brand-name drugs, unless you or your physician specifically directs otherwise. Ask your doctor or pharmacist whether safe, effective, and less expensive generic drugs are right for you. Or call Medco at the number on your Member ID card and ask to speak with a pharmacist. Pharmacists are available 24 hours a day, 7 days a week, to answer questions concerning your prescription.

If you live in Texas, you have a right to refuse generic substitution. In many cases, choosing a brand-name product will result in a higher co-payment. **Check the box if you do not want a less expensive, generic version of your medication.** Please note that this only applies to this prescription and future refills of this prescription.

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

### If you have Medicare Part B coverage

Medco does not submit prescription drug claims to Medicare Part B. Check your Medicare Part B coverage to determine whether Medicare Part B covers your prescription(s) **and** whether it will cost you less to use a Medicare Part B participating pharmacy. For a list of Medicare Part B participating pharmacies, call your local Medicare carrier or call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**. For questions about your Medco-administered coverage, please call **1-800-596-4645**.

**If you need additional information or assistance,** visit us online at [www.medco.com/medd](http://www.medco.com/medd) or call Medco Customer Service at **1-800-596-4645**. TTY/TDD users should call **1-800-716-3231**.

Please return in the enclosed postage-paid envelope or return to the address provided.

**Do not use staples or paper clips.**

N00UAA9A

MEDCO HEALTH SOLUTIONS OF NETPARK, L.L.C.  
PO BOX 30493  
TAMPA FL 33630-3493



FOLD HERE

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## Health, Allergy & Medication Questionnaire

Your answers to the following questions will help us provide your prescription drug benefit services including, for example, filling your prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know what prescription and nonprescription medications you are currently taking. We also need to know if you have any known allergies, conditions, or diseases.

**Please complete this questionnaire only for the person whose name is on the ID card.**

- If your health, allergy and/or medications information does not fit on the form you can provide additional information on plain paper and attach to this form.
- If you need additional forms, you may call your toll-free Customer Service number located on the back of your ID card.
- Return this questionnaire with your prescriptions and your completed **Medco By Mail** order form in the envelope provided.

### Section 1: Member Identification and Contact

		<input type="radio"/> M <input type="radio"/> F Gender
Group (located on your ID Card)	Member Number (Located on your ID Card)	

First Name	M.I.	Last Name
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Street Address	City
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State	Zip	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 20%; text-align: center;">MM</td> <td style="border-bottom: 1px solid black; width: 20%; text-align: center;">DD</td> <td style="border-bottom: 1px solid black; width: 60%; text-align: center;">YYYY</td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: small;">Date of Birth</td> </tr> </table>	MM	DD	YYYY	Date of Birth			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>												
MM	DD	YYYY																			
Date of Birth																					
			Your home telephone number																		

### Section 2: Prescription Medications.\* Please list the current **prescription medications** you are taking.

\*Information can be found on the prescription labels. If none, please check here.  NONE

Prescription Medication	Prescription Medication

Please attach names of **additional prescription medications** if there is not enough room on this page.

### Section 3: Nonprescription Medications. Please list all **nonprescription medications** you take on a regular basis that do not require a prescription from a doctor, such as: aspirin, ibuprofen, *Advil*<sup>®</sup>, *Motrin*<sup>®</sup>.

If none, please check here.  NONE

Nonprescription Medication	Nonprescription Medication

Please attach names of **additional nonprescription medications** if there is not enough room on this page.

**Please continue on the other side to tell us about any health, allergy or medical conditions.**

**Section 4: Drug Allergy Conditions.** Please fill in the circle **ONLY** if you have had an allergy or bad reaction to this medication in the past. If you have had an allergy to a medication not listed below, please print the name of that medication in the blank spaces at the bottom of this section.

Penicillins/cephalosporins	Such as <i>Amoxil</i> <sup>®</sup> , amoxicillin, ampicillin, <i>Ceclor</i> <sup>®</sup> , <i>Ceftin</i> <sup>®</sup> , <i>Keflex</i> <sup>®</sup> , cephalexin	<input type="radio"/>
Tetracycline antibiotics		<input type="radio"/>
Erythromycin, <i>Biaxin</i> <sup>®</sup> , <i>Zithromax</i> <sup>®</sup>		<input type="radio"/>
Codeine	Such as <i>Robitussin AC</i> <sup>®</sup> , <i>Tylenol #3</i> <sup>®</sup>	<input type="radio"/>
Non-steroidal anti-inflammatory drugs (NSAIDs)	Such as ibuprofen, <i>Advil</i> <sup>®</sup> , <i>Motrin</i> <sup>®</sup>	<input type="radio"/>
Aspirin (salicylates)		<input type="radio"/>
Sulfa drugs	Such as <i>Septra</i> <sup>®</sup> , <i>Bactrim</i> <sup>®</sup> , TMP/SMX	<input type="radio"/>
Iodine		<input type="radio"/>
If there is an allergy to a medication that is not listed above, please print the name of that medication in the space below. Example: <i>morphine</i>		

**Section 5: Medical Conditions.** Please fill in a circle **ONLY** if a doctor ever said that you have had any of the following conditions.

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

**Please return the questionnaire along with your prescriptions and your completed Medco By Mail order form to the address printed on the order form.**

**Did you complete both sides?**

**Thank you very much.**