

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)

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 |
|------------|------|-----------|

| | |
|----------------|------|
| Street Address | City |
|----------------|------|

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------------|-----|---|----|------|----|---|------|---------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| State | Zip | <table style="width: 100%; text-align: center; font-size: small;"> <tr> <td style="border-bottom: 1px solid black; width: 20px;">MM</td> <td style="border-bottom: 1px solid black; width: 20px;">/</td> <td style="border-bottom: 1px solid black; width: 20px;">DD</td> <td style="border-bottom: 1px solid black; width: 20px;">/</td> <td style="border-bottom: 1px solid black; width: 40px;">YYYY</td> </tr> <tr> <td colspan="5">Date of Birth</td> </tr> </table> | MM | / | DD | / | YYYY | Date of Birth | | | | | <table style="width: 100%; text-align: center; font-size: small;"> <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> </tr> <tr> <td colspan="10">Your home telephone number</td> </tr> </table> | | | | | | | | | | | Your home telephone number | | | | | | | | | |
| 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*[®], *Motrin*[®].

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> [®] , amoxicillin, ampicillin, <i>Ceclor</i> [®] , <i>Ceftin</i> [®] , <i>Keflex</i> [®] , cephalexin | <input type="radio"/> |
| Tetracycline antibiotics | | <input type="radio"/> |
| Erythromycin, <i>Biaxin</i> [®] , <i>Zithromax</i> [®] | | <input type="radio"/> |
| Codeine | Such as <i>Robitussin AC</i> [®] , <i>Tylenol #3</i> [®] | <input type="radio"/> |
| Non-steroidal anti-inflammatory drugs (NSAIDs) | Such as ibuprofen, <i>Advil</i> [®] , <i>Motrin</i> [®] | <input type="radio"/> |
| Aspirin (salicylates) | | <input type="radio"/> |
| Sulfa drugs | Such as <i>Septra</i> [®] , <i>Bactrim</i> [®] , 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> | | |
| | | |
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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.