medco®

MEDCO BY MAIL
ORDER FORM

1 Member Information Please verify or provide member information below.

Member ID: _____

Group: _____

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 Fill out a separate section for each person requesting a prescription fill. If he/she has more than one prescription from the same doctor, complete just one section but include all prescriptions in the envelope provided. If a person has prescriptions from more than one doctor, complete a new section for each doctor and include all prescriptions. Additional patient/doctor space is provided on the next page.

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date(MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ❑M ❑F

Patient's relationship to member ❑Self ❑Spouse ❑Dependent ❑Domestic partner

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 ❑Domestic partner

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. To enroll for e-check payments, complete and return the e-check form (fifth page printed) with your order.

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)

X _____
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.)

Mailing instructions are provided on the next page

Patient/doctor Information continued

First name

Last name

Birth date(MM/DD/YYYY) Sex

❑M ❑F

Patient's relationship to member

❑Self ❑Spouse ❑Dependent ❑Domestic partner

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 ❑Domestic partner

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).

Complete a patient/doctor section for each person with a prescription.

Be sure you have filled out the Health & 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** and click "Price a medication." To avoid processing delays, call Member Services to enroll in our e-check program or 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.

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).** For questions about your Medco-administered coverage, please call Member Services.

If you need additional information or assistance, visit us online at **www.medco.com** or call Medco Member Services.

Mailing instructions

Using a business-size envelope, send the following items to the address shown on the right:

Do not use staples or paper clips.

- Your prescriptions or refill slips
- Order form
- Health, Allergy & Medication Questionnaire
- Your payment
- E-check enrollment form (optional)

Medco Health Solutions of Fairfield
P.O. Box 747000
Cincinnati, OH 45274-7000

NMSFNP1W REV 12/07

X00000-00000-000-0000 12/07

Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help us provide your prescription drug 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 person in the household eligible for prescription drug benefits with **Medco By Mail.**
- If you need additional forms you may copy this form or call your toll-free Member Services number.
- **Please remember to print your group and member number on both pages.**
- **Return this questionnaire with your prescription or refill order form.**

Section 1 : Member Identification and Contact *(Group and Member number required on all pages)*

Group Number

Member Number *(Located on your pharmacy benefit card and/or in your benefit information)*

Daytime Telephone Number

Member/Subscriber First Name **M.I.** **Last Name**

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

Section 2 : Drug Allergy Conditions

For each covered family member, include their first 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 your allergy is not listed, please print only the name of the medication allergy in the bottom section of this chart.
Correct way to mark circles: ● ***Please use blue or black ink.***

Please add last name if different than member	Member	Spouse	Dependent	Dependent	Dependent
First name :					
Date of Birth (MM/DD/CCYY) :					
Gender :	O M O F	O M O F	O M O F	O M O F	O M O F
Penicillin/cephalosporin Antibiotics (e.g. ampicillin, Keflex ®)	O	O	O	O	O
Tetracycline antibiotics	O	O	O	O	O
Erythromycin, Biaxin ®, Zithromax ®	O	O	O	O	O
Codeine (e.g. Tylenol #3®)	O	O	O	O	O
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, Advil®,Motrin®)	O	O	O	O	O
Aspirin (e.g. salicylates)	O	O	O	O	O
Sulfa drugs	O	O	O	O	O
Iodine	O	O	O	O	O
If there is a drug allergy to report and not listed above, please print only the name of the drug in the space. Example : Morphine ——————————>					

Please continue on next page to tell us about any medical conditions.

Group Number	Member Number

Section 3 : Medical Conditions

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

	Member	Spouse/SSDP	Dependent	Dependent	Dependent
First name :					
Heart Failure (weak heart)	O	O	O	O	O
High blood pressure ***(hypertension)***	O	O	O	O	O
Heart attack or angina	O	O	O	O	O
High cholesterol ***(hypercholesterolemia)***	O	O	O	O	O
Stroke	O	O	O	O	O
Chronic bronchitis or emphysema ***(COPD)***	O	O	O	O	O
Asthma	O	O	O	O	O
Allergies, runny nose, hay fever ***(allergic rhinitis)***	O	O	O	O	O
High blood sugar ***(diabetes)***	O	O	O	O	O
Thyroid disease	O	O	O	O	O
Peptic, stomach or duodenal ulcer	O	O	O	O	O
Gastric reflux, heartburn or esophagitis ***(GERD)***	O	O	O	O	O
Inflammatory bowel disease ***(colitis, Crohn's disease)***	O	O	O	O	O
High pressure in the eyes ***(glaucoma)***	O	O	O	O	O
Seizures	O	O	O	O	O
Poor circulation in legs (peripheral vascular disease)	O	O	O	O	O
Trouble with blood not clotting properly	O	O	O	O	O
Enlarged prostate (benign prostatic hyperplasia, ***BPH)***	O	O	O	O	O
Arthritis	O	O	O	O	O
Osteoporosis	O	O	O	O	O
Depression	O	O	O	O	O
Migraine headaches	O	O	O	O	O
Print other medical conditions Example : Glaucoma →					

For more information about Medco, please visit us online
at www.medco.com.

Please complete both pages and staple together.
Please return the questionnaire with your Medco Delivery form or refill order form.
Thank you very much.

medco®

Pay for medications with e-check. It's easy, convenient, and secure!

Medco now offers e-check to easily and conveniently pay for medications.

With e-check, one of the most secure payment methods available today, the co-payment or coinsurance is automatically deducted from your checking account. And you have a 10-day grace period between the time we send the order and the day the amount is deducted from your checking account.*

To enroll and authorize Medco, just complete the form on the back and return it with your next order!

Authorization
I authorize Medco to initiate a debit entry to the checking account provided on the back of this form. This authorization permits Medco to charge unpaid balances and future orders **made by all covered dependents** to my account, based on my authorization provided by mail, phone, or web. On future orders, Medco will include the amount to be charged to my checking account with the order. I acknowledge that the origination of ACH transactions to the account must comply with the provisions of U.S. law. This authorization will remain in effect until I have canceled it.

*Please note that if there are insufficient funds at the time Medco submits the funds transfer request, Medco will charge a $10 fee. Your bank also may charge a nonsufficient funds fee.

E-CHECK ENROLLMENT FORM

To pay for medications by e-check, please complete the information below. You'll find your bank routing number and account number on the front of your personal checks. The routing number is the 9-digit number located in the lower left-hand corner. Your account number is the number immediately to the right of the routing number. **For more information, or to enroll online, visit www.medco.com.**

Member name: _____ Date: ___/___/___

Name of bank account holder: _____

Address of bank account holder: _____

Bank account number: | | | | | | | | | | | | | | | | | |

Bank routing number: | | | | | | | | |

Medco invoice number: _____ Signature: _____