

New Prescription Mail-In Form

1 Please use black or blue ink and mail this completed order form with your new prescription(s). DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Primary Member ID Number: Plan Name:		(Additional coverage, if applicable) Secondary Member ID Number: Plan Name:	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number ()
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email	
Physician's Name		Physician's Phone Number ()	

2 Health History – please check all that apply.

If you are a new customer or your allergies or health conditions have changed, please indicate all that apply. The information you provide will allow a more complete review of your current medication request.

Medication Allergies:	<input type="checkbox"/> Cephalosporins (e.g. Cephalexin)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> None	<input type="checkbox"/> Codeine	<input type="checkbox"/> Quinolones (e.g. Ciprofloxacin)	_____
<input type="checkbox"/> Amoxicillin/Ampicillin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Sulfa Medications	_____
<input type="checkbox"/> Aspirin	<input type="checkbox"/> NSAIDs (e.g. Ibuprofen)	<input type="checkbox"/> Tetracyclines	_____
Health Conditions:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> None	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Allergies – Seasonal	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Thyroid Disease	_____

Please list any over-the-counter or herbal medications you take regularly:

Please complete order information on back side. 

3 Generic Substitution

FDA-approved generic equivalents will be dispensed for brand-name medications whenever possible, unless you or your physician indicate otherwise. If you require brand-name medications, please list those medications in the Notes to Pharmacy section below with a brand-name only notation. Note: brand-name medications may be subject to a higher cost.

Notes to Pharmacy:

4 Payment and Shipping Information – do not send cash.

Standard delivery is at no charge. Most orders arrive about 7 days from the date your completed order is received. If clarification of your order is required, delivery may take longer. If you would like overnight shipping, please indicate below. Please note that expedited shipping only affects shipping time, not the processing time of your order.

Ship overnight. Add \$12.50 to order amount (subject to change).

Check enclosed. All checks must be signed and made payable to PartnersRx.

Charge to my credit card on file.

Charge to my NEW credit card.

New Credit Card Number:

Expiration Date (Month/Year): /

Signature: _____ Date: _____

This credit card will be billed for medicine costs, expedited shipping (if applicable), and any outstanding balances. It will also be billed for all future orders, unless you provide a different form of payment. Payment in excess of amounts due will be credited to your mail order account. If method of payment is not indicated, we will apply the charges to the credit card on file.

P.O. Box 509075, San Diego, CA 92150-9075

UHEX3250018_000

UHEX3209885_001

Client & Agency Team	Project Details	Timeline	Specs
Client Supervisor: Gretchen Cannon	Project Name: Order Form/BRE Combo - PartnersRx - San Diego - Non-BRM	Date Assigned: 8/03/10	Colors: 1/1 (Black)
TA Manager: Chase Oborn	FileName: Order_Form_BRE_PartnersRx_SD_NON-BRM_UHEX3250018_000_TA7406_R2_0803.indd	Date Due: 8/03/10	Dimensions: 8.5" x 11"
TA Creative: Deril Johnson	TA Job Number: TA7406	Stage: Client Review	Format: Form
TA Production:	Code: UHEX3250018_000	Revision: R2	Software: Adobe InDesign CS3

Return Address



**Postage
Required.**
Post Office will
not deliver
without proper
postage.

**PO BOX 509075
SAN DIEGO CA 92150-9075**

