Medco Pharmacy®
MAIL-ORDER FORM

The **Medco Pharmacy** is part of the Express Scripts family of pharmacies

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
_____
_____
_____

(Express Scripts 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 ❑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 Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the number on your member ID card.

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

X _____
Cardholder signature

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

❑Rush the mailing of this shipment ($15, 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.

Mailing instructions are provided on the back of this form.

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 (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective and less expensive generic drugs.

Complete the Health, Allergy and 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 the number located on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitue generic formulations of medication, unless you or your doctor specifically directs otherwise.

❑ Pennsylvania and Texas laws permits pharmacists to submit a less expensive generically equivalent drug for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.**
Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information, log in to Express-Scripts.com or call Member Services at the number located on your ID card. TTY/TDD users should call 1-800-759-1089.
Federal law prohibits the return of dispensed controlled substances.

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