# NEW PATIENT HOME DELIVERY FORM

Please complete all portions of this form by printing in **ALL CAPITAL LETTERS** using **black ink**.
If there are more than three (3) family members, write the information on a separate piece of paper.

## 1. PERSONAL INFORMATION

**Cardholder ID Number**
(Refer to your Plan card)

**Cardholder First Name** **M.I.** **Last Name**

**Drug Allergies:** (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)
Tetracycline (07) Erythromycin (09) Other:
No Known Drug Allergies (00) **Birth Date** M M – D D – Y Y Y Y **Gender**

FOLD HERE

**Provide a street address. Certain medications cannot be delivered to a post office box.**

Mailing Address

City

State ZIP Code –

**Phone #** – – Your phone number is used to provide information about your order.

**Physician Last Name** **Physician Phone #** – –

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**Family Member 1 First Name** **M.I.** **Last Name**

**Drug Allergies:** (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)
Tetracycline (07) Erythromycin (09) Other:
No Known Drug Allergies (00) **Birth Date** M M – D D – Y Y Y Y **Gender**

**Physician Last Name** **Physician Phone #** – –

**Family Member 2 First Name** **M.I.** **Last Name**

**Drug Allergies:** (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)
Tetracycline (07) Erythromycin (09) Other:
No Known Drug Allergies (00) **Birth Date** M M – D D – Y Y Y Y **Gender**

**Physician Last Name** **Physician Phone #** – –

**Family Member 3 First Name** **M.I.** **Last Name**

**Drug Allergies:** (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)

Tetracycline (07) Erythromycin (09) Other:

No Known Drug Allergies (00) **Birth Date** MM – DD – YYYY **Gender**

**Physician Last Name** **Physician Phone #** – –

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## 2. PAYMENT INFORMATION

Include payment with your order. **DO NOT SEND CASH.** Standard delivery of your order is **FREE** and should arrive within 14 days from the date we receive your order.

NOTE: Your check card or credit card will be charged according to your prescription plan. All orders will be charged to this card, unless payment (check or money order) accompanies the order.

**Check Card** **Credit Card**

**Card #** **Expiration Date** MM – YY

**Cardholder Name** ______________________

Print name as it appears on card

x AUTHORIZED SIGNATURE

NOTE: If paying by check or money order, please refer to your prescription plan materials for copay.

**Check/Money Order** **Amount Enclosed $** .

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## 3. SIGNATURE REQUIRED

Check any options that apply and sign the following statement.

I prefer non-child resistant (easy open) caps.

I request that this and future orders be shipped "signature required" for an additional charge.

I certify that all the information on this form is correct, including any selections made for sending my order "signature required" or for non-child resistant (easy open) caps. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment, or health care operations.

x SIGNATURE REQUIRED

## 4. REMINDER

- Make sure the following information is clear and easy to read on your prescription:
  **Doctor Information**: Name, Signature, and DEA Number. If there are multiple doctors, circle your doctor's name.
  **Patient Information**: First and Last Name, Address, Date of Birth, and ID Number.
  **Prescription Information**: Date Written, Drug Name and Strength, Medication Directions, Medication Quantity, and Number of Refills.
- Prescriptions that do not include this information may be returned to you unfilled.
- FDA approved generic medications will be dispensed when allowed by your physician, subject to the terms outlined in your plan.

**QUESTIONS ABOUT YOUR PHARMACY BENEFIT?**
**CALL THE CUSTOMER SERVICE NUMBER THAT WAS PROVIDED TO YOU.**

MLRHARBEN-N HLB7427 REV 01/06/2006

Postage Required Post Office will not deliver without proper postage

EXPRESS SCRIPTS®

**HOME DELIVERY SERVICE**
**PO BOX 1088**
**BENSALEM PA 19020-5088**