Cleveland Clinic

Employee Health Plan Total Care/Cleveland Clinic Pharmacies
Home Delivery Service: Processing Form

Date: _____ /_____ /_____

E-mail: _____

Employee Name: _____

Prescription Insurance ID No.: _____

Employee ID Badge No. *(Required)*: _____

Badge Encoded No.: _____ *(6 digit number on back of ID badge)*

Patient Name (*If different*): _____

Patient Medical Record No.: _____

Patient Date of Birth: _____ /_____ /_____

Primary Shipping Address:

Street: _____

City/State/Zip: _____

Contact Phone No.:_____

Patient Address:

Street: _____

City/State/Zip: _____

Alternate Phone No.: _____

List prescriptions being filled *(name or R_X number)*:

1. _____
2. _____
3. _____

Is Generic OK? ❑ Yes ❑ No, Brand Name is requested:

_____

*If these are prescriptions from another pharmacy, please indicate the following:

Name and Phone No. of Pharmacy:

_____

R_X Number's or Name(s) of Medications:

_____

_____

_____

Drug Allergies *(Please list)*: _____

Payment Method:

❑ **FSA Card (PayFlex):** Please also indicate an alternate form of payment should there be an insufficient balance. If PayFlex is your primary choice for payment, we will need a credit card to process any balance in excess of the PayFlex card.

FSA Card No.: _____

Expiration Date: _____

Signature: _____

❑ **Credit Card (Visa/Mastercard/Discover/AMEX)**

Credit Card No.: _____

Expiration Date: _____

Signature: _____

❑ **Payroll Deduction**

I hereby authorize Cleveland Clinic Pharmacies to enroll me in the Payroll Deduction for Pharmacy Purchases Program. I understand that my badge is the property of the Cleveland Clinic Foundation and must be returned to the ID badge Department upon termination of employment or upon request by the Cleveland Clinic Foundation. I further understand that I will be responsible for all charges made with this badge and I hereby authorize those charges to be deducted from my paycheck. Charges made during a payroll period will be reflected as "Pharmacy" on the corresponding paycheck stub. Furthermore, I agree to protect this badge from unauthorized use and to pay Cleveland Clinic Pharmacies any outstanding balance upon termination of my employment or withdrawal from this program. The information above will be held confidential. I recognize that any unauthorized and/or illegal use of any badge is classified as a major infraction and will be grounds for disciplinary action in accordance with CCF Policy 121.

I have read the above information and agree to all of the above and authorize use of one time payroll deduction for the entire amount due.

Signature: _____ Date: _____ /_____ /_____ **Use:** ❑ 1 Pay Cycle ❑ 2 Pay Cycles

At what amount would you like us to contact you before processing your order? $ _____

Phone: 216-328-6075
Fax: 216-328-6076

Mail to: Home Delivery Service
P.O. Box 25220
Garfield Heights, OH 44125-0220

All hard copy prescriptions must be mailed with this form
Home Delivery turnaround time is five business days from receipt of this form and your prescription(s)
For faster service of your ***refills***, please call 216-445-MEDS (6337) or 1-866-650-6337 to use our automated refill system.
***Note:** Prescriptions transferred from a retail pharmacy can only be filled for a 30 day supply.
If you would like to order a 90 day supply, have your physician call in or write a new prescription to be filled for a 90 day supply.