FOLD HERE



# **MEDCO BY MAIL**ORDER FORM



Member ID:	☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:     New shipping address:			
Group:				
Name: Street Address:				
Street Address:				
Street Address:				
City, ST, ZIP:	(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:			
	te section for each person requesting a prescription fill. ne doctor, complete just one section but include all prescriptions from more than one doctor, complete a new dditional patient/doctor space is provided on the next page.			
irst name Last na				
Birth date (MM/DD/YYYY) Sex Patient	t's relationship to member			
	Spouse Dependent Domestic partner			
Poctor's last name	1st initial Doctor's phone number			
First name Last na	me			
Birth date (MM/DD/YYYY) Sex Patient	t's relationship to member			
□ M □ F □ Self	□Spouse □Dependent □Domestic partner			
Doctor's last name	1st initial Doctor's phone number			
	check, money order, or credit card. Make checks and , Inc., and write your member ID number on the front. the e-check form (third printed page) with your order.			
Number of prescriptions sent with this order: $lacksquare$				
· · ·	□Credit card □Send bill			
Payment options:   —e-check —Payment enclosed  For credit card payments:	Credit card Send bill  Credit card number			
Payment options:  e-check Payment enclosed  For credit card payments:				

Mailing instructions are provided on the next page.

Patient/doctor information contin	ued
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
First name  Birth date (MM/DD/YYYY) Sex  M F	Last name Patient's relationship to member Self Spouse Dependent Domestic partner
Birth date (MM/DD/YYYY) Sex	Patient's relationship to member

## mportant 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

Medico does not submit prescription drug daims 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 Medico-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.

Mail your prescription(s) (and refill slips), all forms (order form and the e-check enrollment form and Health and Medication Questionnaire, if applicable), and your payment in a standard business envelope to the appropriate mail-service pharmacy. You'll find the address online in the "Forms and cards" section of our website, **www.medco.com**. **Do not use staples or paper clips.** 



# 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 below and return it with your next order!

#### **Authorization**

I authorize Medco to initiate a debit entry to the checking account provided below. This authorization permits Medco to charge future orders **made by all covered dependents** to my account, based on my authorization provided by mail, phone, or web. In all cases, 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	7000F
To pay for medications by e-check, please complete the information below. You'll bank routing number and account number on the front of your personal checks. 9-digit number located in the lower left-hand corner. Your account number is the the right of the routing number. For more information, or to enroll online, visit was a superior of the routing number.	The routing number is the number immediately to
Member name:	Date:
Name of bank account holder:	
Address of bank account holder:	
Bank account number:	
Bank routing number:	
Medco invoice number: Signature:	

# 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.

<b>Section 1: Member</b>	r Identification	and Conta	ct (Grou	and Mo	ember n	umbei	requi	red or	ı all <sub>I</sub>	pages	)
						-		[			
Group Number	Member Number (abenefit card and/or in your		acy	Dayti	me Tel	ephor	ne Nu	mber			
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:	OM OF	OM OF	OM OF	OM OF	ом оғ	
Penicillin/cephalosporin Antibiotics (e.g. ampicillin, Keflex <sup>®</sup> )	О	0	О	О	О	
Tetracycline antibiotics	O	О	О	О	О	
Erythromycin, Biaxin®, Zithromax®	О	О	О	О	О	
Codeine (e.g. Tylenol #3 <sup>®</sup> )	О	О	О	О	0	
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, Advil <sup>®</sup> , Motrin <sup>®</sup> )	О	0	0	О	О	
Aspirin (e.g. salicylates)	O	О	О	О	О	
Sulfa drugs	O	О	О	О	О	
Iodine	O	О	О	О	О	
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						

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	Dependent	Dependent	Dependent
First Name:					
Heart Failure (weak heart)	О	О	О	О	О
High blood pressure (hypertension)	О	О	О	О	О
Heart attack or angina	О	О	О	О	О
High cholesterol (hypercholesterolemia)	О	О	О	О	О
Stroke	О	О	О	О	0
Chronic bronchitis or emphysema (COPD)	О	О	О	О	О
Asthma	О	О	О	О	О
Allergies, runny nose, hay fever (allergic rhinitis)	О	О	О	О	О
High blood sugar (diabetes)	О	О	О	О	О
Thyroid disease	О	О	О	О	О
Peptic, stomach or duodenal ulcer	О	О	О	О	О
Gastric reflux, heartburn or esophagitis (GERD)	О	О	О	О	О
Inflammatory bowel disease (colitis, Crohn's disease)	О	О	О	О	О
High pressure in the eyes (glaucoma)	О	О	О	О	О
Seizures	О	О	О	О	О
Poor circulation in the legs (peripheral vascular disease)	О	О	О	О	О
Trouble with blood not clotting properly	О	О	О	О	О
Enlarged prostate (benign prostatic hyperplasia, <b>BPH</b> )	О	О	О	О	О
Arthritis	О	О	О	О	0
Osteoporosis	О	О	О	О	0
Depression	О	О	О	О	О
Migraine headaches	О	О	О	О	0
Print other medical conditions not listed above in the space provided. 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 prescription or refill order form.

Thank you very much.