

Medco By Mail ORDER FORM



A UnitedHealth Group Company

UnitedHealthcare®



1 Customer information: Please verify or provide customer information below.

Subscriber #: _____

Rx Grp #: **UHEALTH**

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime phone:

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: _____@_____.

☐ New shipping address: _____

(Medco will keep this address on file for all orders from this subscriber until another shipping address is provided by any person in this plan.)

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 one envelope.

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to subscriber

☐ Self ☐ Spouse ☐ Dependent

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 subscriber

☐ Self ☐ Spouse ☐ Dependent

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 Medco Health Solutions, Inc.**, and write your subscriber ID number on the front. You can enroll for e-check payments and price medications at **www.myuhc.com**, or call **1-800-948-8779**.

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

Expiration date

☒ _____

M M Y Y

Cardholder signature

Credit card number

☐ I authorize Medco to charge this card for all orders from any person in this plan.

☐ 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.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

Patient's relationship to subscriber

☐ M ☐ F☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

Patient's relationship to subscriber

☐ M ☐ F☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail order copayment regardless of the days' supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with 3 refills.

Complete the Health, Allergy & 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 pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Customer Care number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1-800-MEDICARE (1-800-633-4227).

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

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

For additional information or help, visit us at **www.myuhc.com** or call the Customer Care number on your ID card. TTY/TDD users should call 1-800-759-1089.

Mailing instructions: Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P.O. BOX 747000
CINCINNATI OH 45274-7000

