Blue Cross and Blue Shield of Texas
Mail Order Form — PrimeMail® Pharmacy

BlueCross BlueShield of Texas†

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

For information about your pharmacy benefits, to preregister or to download additional order forms or a physician fax form, visit the Blue Cross and Blue Shield of Texas Web site at **www.bcbstx.com** or call customer service at 877.299.2377 for HMO Blue® Texas members or 800.521.2227 for all other members.

Member and Dependent History Section information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

MEMBER AND DEPENDENT HISTORY SECTION

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Member ID Number (on face of member ID card) Group Number

Member Last Name Sex: M F

Member First Name MI Birth Date (MM/DD/YYYY)

PCN (back of ID card) Member Phone Number – –

Permanent Address

City State Zip Code

Email Address

* Please detail "other allergy " or "other condition," including related medications. _____

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other Allergy*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Condition	○ Hypertension	○ Ulcer	○ Other Condition*

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

Email Address

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Cond.	○ Hypertension	○ Ulcer	○ Other*

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Cond.	○ Hypertension	○ Ulcer	○ Other*

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Cond.	○ Hypertension	○ Ulcer	○ Other*

- **Do you want the Generic?** ____ **Yes** (if available and your doctor permits) ____ **No**
- Some health plans require the patient to pay the difference between generic and brand name cost. State law allows pharmacist to substitute a less expensive generically equivalent drug for a brand drug unless you or your physician directs otherwise.

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PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescriptions with this completed form to: **Blue Cross and Blue Shield of Texas c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **877.774.6360** provided you have either previously completed and submitted this form or registered at **www.bcbstx.com**

For **REFILL** prescriptions you may use:

- **PHONE** — Call our automated refill line at 877.357.7463.
- **WEB** — Visit **www.bcbstx.com**
- **MAIL** — Mail this form with the refill information completed to: **Blue Cross and Blue Shield of Texas c/o PrimeMail Pharmacy P.O. Box 650041, Dallas, TX 75265-0041**

Prescription	Member	Spouse	Dependent	Patient Name	Physician Name/Phone Number/Drug Name (for new prescriptions only)	Prescription Numbers (for refills only)
1	○	○	○			
2	○	○	○			
3	○	○	○			
4	○	○	○			
5	○	○	○			
6	○	○	○			

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

Do not send cash. Orders received without payment will delay processing. Credit card is the only payment option for faxed orders. If you have questions about your payment amount, call the Prescription Drug Inquiry Unit at **877.299.2377 for HMO Blue Texas members** or **800.521.2227 for all other members**.

○ **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

Check Amount: _____ Check Number: _____

○ **Payment by credit card** (Provide information below) ○ MasterCard ○ Visa ○ American Express ○ Discover

○ **Use credit card on file, with the last four digits:** ☐☐☐☐

○ **Use alternate credit card number** Expiration Date (MM/YYYY)

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

○ **Use this card for all future orders**

Credit card holder's signature

SHIPMENT SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

○ **Regular** — no charge ○ **Second Business Day*** ○ **Next Business Day*** ***Additional costs charged to you**

If you've chosen Second Business Day or Next Business Day shipping, we are unable to ship to P.O. boxes. Shipping address must be a physical location.

○ **Ship to Permanent Address** ○ **Spanish prescription labels**

Alternate Shipping Address (If different than permanent address)

City State Zip Code Phone Number

Above address is: ○ **For this order only** ○ **For this and all future orders**

All medications in this order will be sent to the address provided on this form. If a family member's medication needs to be delivered to a separate address, please submit a separate order form.

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

† A division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association