Medco By Mail Order Form

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FOLD BACK HERE

FOLD BACK HERE

For New Prescriptions
Fill out one line of the Patient Information section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number.

For Refills
To order from our website: **www.medco.com.** Have your member ID number and prescription (Rx) number on hand. Your 12-digit prescription or Rx number can be found on your refill slip.

To order by phone: Call **1-800-4REFILL (1-800-473-3455)** to use the automated refill system. Have your member ID number and your refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For All Mail Orders
Place all prescriptions and refill slips together with this completed order form and your co-payment in the enclosed return envelope.

If You Need Additional Help
A pharmacist is available 24 hours a day, 7 days a week for emergency consultations. Call Member Services at **1-800-903-8346**. The best time to call is in the afternoon, Tuesday through Friday.

Member Information

Member ID: _____

Group: BCBSMLG

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Evening telephone ☐☐☐ ☐☐☐ ☐☐☐☐

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

_____@_____._____

Shipping address if different from your mailing address

Check if: ☐ Temporary ☐ Permanent

_____

_____

_____

Patient Information — complete one line for each new prescription *(Do not complete for refills)*

	Patient name	Patient's relation to plan member *(fill in one)*	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
2		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
3		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No

Order Information

Total number of medications in this order
(including all refills and new medications) ☐

Subtotal of this order $☐☐☐.☐☐

Optional expedited shipping
$9.00 (subject to change) ☐☐.☐☐

Total enclosed
(do not send cash) $☐☐☐.☐☐

Paying by Credit Card? ☐Visa ☐MC ☐Disc/NOVUS ☐AmEx ☐Diners

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CREDIT CARD NUMBER

M ☐☐ Y ☐☐ EXPIRATION DATE

X _____ CARDHOLDER SIGNATURE

☐ **Check here to have all orders billed to your credit card.**
By doing so, you authorize Medco to keep your card number on file and bill all future orders and any outstanding balances directly to your credit card. To enroll by phone, please call 1-800-948-8779.

Paying by check? Write your member ID number on your check or money order made payable to Medco Health Solutions, Inc.

MEDCO
PO BOX 182050
COLUMBUS OH 43272-4404

FORM #HE904692

Please take a minute to make sure . . .

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your member ID number on any check or money order.**
- **You have filled out the Health, Allergy & Medication Questionnaire. This information will help Medco better serve your prescription drug needs.**

Expedited shipping available

You should allow 7 to 11 days for normal delivery of your medications. For an additional fee, your order will be shipped by an expedited service offered in your area. This option must be chosen when you make the order, and it cannot be applied after an order has already been processed.

Additional instructions

If you elect to have this and all future orders automatically charged to your credit card (by checking the box on the front or enrolling by phone), bear in mind that the automated payment plan feature will apply to all mail orders, whether or not they are covered by your plan. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If so, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance has been paid.

You can call 1-800-948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Get more information from our website

Visit us at **www.medco.com**.

Ohio Law allows a less expensive, generically equivalent drug to be substituted for certain brand-name drugs unless you or your physician directs otherwise.

Health, Allergy & Medication Questionnaire (HMQ)

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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 or any eligible person in the household has any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for prescription drug benefits.
- If you need additional forms you may call your toll-free Member Service Number or you may print a form on-line at **www.medco.com.**
- **Return this questionnaire with your prescription or refill order form in the envelope marked MEDCO BY MAIL Order Center.**

Section 1: Member Identification and Contact

Group Number

Member Number
(Located on your pharmacy benefit card and/or in your benefits information)

Daytime Telephone Number

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 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 medication is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ● Please use blue or black ink.

	Member	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name:					
Add last name if different than member					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillin/cephalosporin Antibiotics (e.g. ampicillin, *Keflex®*)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, *Biaxin®*, *Zithromax®*	○	○	○	○	○
Codeine (e.g. *Tylenol #3®*)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	○	○	○	○	○
Aspirin (salicylates)	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Iodine	○	○	○	○	○
Print other drug allergies not listed above in the space provided. Example: *morphine.*					

Please continue on other side to tell us about any medical conditions ☞

Section 3: Medical Conditions

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said ***that this particular family member*** has that condition.

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

USING MEDCO By Mail? It's available to you at **NO EXTRA CHARGE, NO SIGN-UP.** Experience the convenience and savings millions of people are enjoying. Learn more by visiting us at **www.medco.com**.

Please return the questionnaire with your prescription or refill order form in the envelope marked MEDCO BY MAIL Order Center.

Did you complete both sides?

Thank you very much.

NMGNPRF