(Serve you.)

DIRECTRx PHARMACY

prescription transfer form

If you currently use a mail order or local pharmacy to fill your prescriptions, you can easily transfer them to the Serve You DirectRx Mail Order Pharmacy by completing this form. An order will be placed for all prescriptions marked "Fill" on page 2. Questions can be directed to Member & Provider Services who will be happy to assist you.

MEMBER & PROVIDER SERVICES:
800-759-3203

MAIL OR FAX COMPLETED FORM TO:
Serve You DirectRx Pharmacy
P.O. Box 26096
Milwaukee, WI 53226
FAX 866-494-0364

TO TRANSFER PRESCRIPTIONS:
Complete page 1 and the "Prescription Transfer Information" on page 2. Mail or Fax both pages of this completed transfer form along with payment, if applicable.

For additional forms, visit serve-you-rx.com

Please print

CARDHOLDER INFORMATION ☐ Establish a separate account* (see note)

Employer/Health Plan Name: _____

Member ID #: _____ Group #:_____ Gender: ☐ Male ☐ Female

Last Name: _____ First Name: _____ MI: _____

Permanent Address:_____City:_____ State:_____ Zip:_____

Delivery Address:_____City:_____ State:_____ Zip:_____

(*If different than the permanent address)*

Primary Phone #: (_____) _____-_____ ☐Cell ☐Work ☐Home

Secondary Phone #: (_____) _____-_____ ☐Cell ☐Work ☐Home

Email Address: _____

Providing your email address and phone number authorizes us to contact you about your account or our services. Your phone and email information will not be shared with any outside party.

PAYMENT OPTIONS ☐MasterCard ☐VISA ☐American Express ☐Discover

METHOD OF PAYMENT ☐Please keep this credit card on file and automatically use for future Serve You DirectRx Pharmacy orders including those sent by your Provider.

AMOUNT ENCLOSED

$

To use check or money order, contact Member & Provider Services to obtain your payment amount.

☐Check *(payable to: Serve You Custom Prescription Management)* ☐Money Order

To authorize payment by credit card, please provide the account number, expiration date and cardholder's signature.

Credit Card #: _____—_____—_____—_____ Expiration Date *(month/year)*: ___ /_____

Cardholder Signature: _____

Certification and Authorization: I certify that the information on this form is correct and further understand that any benefits are subject to my eligibility for and participation in the medical plan.

NOTE: *All communications, including mailed prescriptions, will be directed to the cardholder. A covered dependent who wishes to receive communications directly should include a request in writing with any prescription order.*

*For each account all prescriptions ordered are sent in the same package. If a family member prefers his or her prescriptions sent separately he or she must establish a separate account. Complete a separate Prescription Transfer Form for each patient and check the 'establish a separate account' box in the cardholder Information section.

Signature: _____ Today's Date *(month/day/year)*: ___ /___ /____

Prescription Transfer Information Please print

PATIENT #1 INFORMATION: ☐ Self ☐ Spouse ☐ Dependent

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ / _____ / _____ Email Address: _____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

PATIENT #2 INFORMATION: ☐ Self ☐ Spouse ☐ Dependent

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ / _____ / _____ Email Address: _____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

PATIENT #3 INFORMATION: ☐ Self ☐ Spouse ☐ Dependent

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ / _____ / _____ Email Address: _____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____

RX #: _____ Drug Name / Strength: _____ ☐ Fill ☐ Do Not Fill At This Time

Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____