

Medco By Mail ORDER FORM



medco®



1 Member information: Please verify or provide member information below.

Member ID: _____

Group: BMIBCBSMLG

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 membership until another shipping address is provided by any person in this membership.)

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 the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex
 M F

Patient's relationship to member
 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 member
 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 member ID number on the front. You can enroll for e-check payments and price medications at www.medco.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

Credit card number

Expiration date

M M Y Y

Cardholder signature

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

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

 M F

Patient's relationship to member

 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 member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Please be sure that 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. 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 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.)

Please take a minute to make sure that 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. If you elect to have this and all future orders automatically charged to your credit card, bear in mind that the automated payment plan feature will apply to all mail

orders.

Automatic generic equivalent substitution of certain brand-name drugs is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want the less expensive, generic drug.** This applies only to the prescription drug(s) on this order.

Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent drug for a brand name drug unless you or your physician direct otherwise. **Check the box if you do not wish a less expensive brand or generic drug "product."**

Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information or help, visit us at **www.medco.com** or call Member Services at 1 800 903-8346. TTY/TDD users should call 1 800 759-1089.

Place your prescription(s), this form, and your payment in the envelope provided. Do not use staples or paper clips.

**MEDCO HEALTH SOLUTIONS OF FAIRFIELD
PO BOX 6575
CINCINNATI OH 45273-7983**



FOLD HERE

FOLD HERE

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 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 <small>(Located on your pharmacy benefit card and/or in your benefits information)</small>	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: <small>Add last name if different than member</small>					
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, <i>Keflex</i> ®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, <i>Biaxin</i> ®, <i>Zithromax</i> ®	○	○	○	○	○
Codeine (e.g. <i>Tylenol #3</i> ®)	○	○	○	○	○
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: <i>morphine</i> .					



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

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.