## HOME DELIVERY ORDER FORM

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<b>1</b> Member information: Please verify or provide member information below.	
Member ID: Group:	Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
Name:	New shipping address:
Street Address: Street Address:	
City, ST, ZIP:	(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)
Daytime phone:	Evening phone:
2 Patient/doctor information: Complete one prescriptions from more than one doctor, com back). Send all prescriptions in one envelope.	<b>section</b> for each person with a prescription. If a person has plete a new section for each doctor (additional sections are on
First name	ast name
	Patient's relationship to member Self 🔲 Spouse 🔲 Dependent
Doctor's last name	1st initial Doctor's phone number
First name	ast name
	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 Express Scripts, and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.	
Number of prescriptions sent with this order:	
Payment options: e-check Payment enclosed Credit card Send bill	
For credit card payments:VisaMCDiscoverAmexDiners	Credit card number
Expiration date       K       M M Y Y       Cardholder signature	I authorize Express Scripts to charge this card for all orders from any person in this membership.

□ Rush the mailing of this shipment (\$21, 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.

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## Mailing instructions are provided on the back of this form.

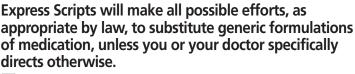
Patient/doctor information continued	
First name	Last name
Birth date (MM/DD/YYYY) Sex	Patient's relationship to member
M □ F	Self Spouse Dependent
Doctor's last name	1st initial Doctor's phone number
First name	Last name
Birth date (MM/DD/YYYY) Sex	Patient's relationship to member
□ M □ F	Self Spouse Dependent
Doctor's last name	1st initial Doctor's phone number

## Important reminders and other information

**Check** that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

**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 prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.



Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive** 

## brand or generic drug.

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

**For additional information** or help, visit us at Express-Scripts.com or call Member Services at the phone number on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

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

EXPRESS SCRIPTS PO BOX 66566 ST. LOUIS, MO 63166-6566