



Medco By Mail Order Form

Benefits Provided by Medco

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 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 into a standard, white, business-size envelope. Write or type the address of the mail service pharmacy on the front of the envelope and mail to Medco. The address can be found on the "forms and cards" page of our website at www.medco.com.

If You Need Additional Help

Call Member Services at the toll-free number on your ID card. The best times to call are Tuesday through Friday afternoons. See the second page of this form for additional instructions.

Member Information

Member ID: _____
Group: _____
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

Shipping address if different from your mailing address

Check if Temporary Permanent

Daytime telephone
Evening telephone

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 <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> 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 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.

Reminder: To maximize your savings, ask your doctor for a 90-day supply (not a 30-day) with refills up to one year as appropriate. You will always be charged the mail-order copay/coinsurance when you send a prescription to the mail-order pharmacy.

FOLD BACK HERE

FOLD BACK HERE

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 and Medication Questionnaire. This information will help Medco better serve your prescription drug needs.**

Expedited shipping available

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 is already 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. Also note that we can only keep one credit card on record at any time.

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 to check the status of your orders, refill medications, obtain valuable health and medication information, and more.

To all Medicare beneficiaries whose private health plan has elected to be billed primary for Medicare Part B coverage:

By choosing the Medco mail-order pharmacy to fill your prescription, you are choosing to use the prescription drug coverage provided by your group health plan. Medco will process your prescription under your group health plan coverage, independent of the Medicare program, and no claim will be submitted to Medicare. If you believe that Medicare may also provide coverage and would like Medicare to pay for your prescription, you should go to a Medicare-participating pharmacy in your area. For a list of convenient Medicare-participating pharmacies, please call your local Medicare carrier or 1 800 MEDICARE. If you have any questions about the difference in coverage between your group health plan coverage and Medicare, please call the number on your ID card .



Group Number

Member Number

Section 3: Medical Conditions

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

For more information about Medco, please visit us online at **www.medco.com**.

Please complete both pages and staple together.

Please return the questionnaire with your prescription or refill order form.

Thank you very much.