Request for Information Update

Fill out electronically, or print using blue or black ink. **One form per member.**
If you have questions or need additional forms, visit ServeYouRx.com.

To assure we have your latest information on file, please complete and return this form with your next refill order or mail it to:

Serve You Home Delivery Pharmacy
10201 West Innovation Drive
Milwaukee, WI 53066
Forms may also be returned via confidential fax to 866-494-0364.

ACCOUNT INFORMATION

Employer/Health Plan Name: ____

Member ID #: __________________ Group #: __________________

Last Name: __________________________ First Name: __________________________ MI: _____

Date of Birth: ________ Gender: ☐ Male ☐ Female Email Address: ______________________________

Permanent Address: ____________________________ City: ________________ State: ______ ZIP: ________

Delivery Address: ____________________________ City: ________________ State: ______ ZIP: ________

(If different than the permanent address) ☐ For this order only ☐ For all orders

Primary Phone #: __________________ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: __________________ ☐ Mobile ☐ Work ☐ Home

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.

Please note: Other household members using the email address provided above may be able to access your health information.

SHIPPING INFORMATION

For each account, all prescriptions ordered will be sent in separate packages. Remember to please complete a separate Request for Information Update form for each account. Overnight shipping available for additional $35 charge.

PAYMENT INFORMATION **Do not send cash.**

Please enter your credit card information you want to keep on file and use for all future Serve You Home Delivery Pharmacy orders. Any outstanding balances will be billed directly to your credit card.

☐ Mastercard ☐ VISA ☐ American Express ☐ Discover

Name as it appears on credit card: ____________________________

Billing Address: ____ Billing ZIP: ________

Credit Card #: ________________________ Expiration Date (month/year): ______

Cardholder Signature: ____________________________ Today's Date (month/day/year): ______

☐ I authorize Serve You Home Delivery Pharmacy to maintain this NEW credit card on file to use as payment for future charges.

Signature: ____________________________ Today's Date (month/day/year): ______

NOTE: All communications will be directed to the primary member on the Enrollment Form. A covered dependent who would like to receive communications directly should include a request in writing to the above address.

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