

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 #: _____ Secondary Phone #: _____

☐ Mobile ☐ Work ☐ Home

☐ 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.