New Prescription Mail-in Order Form

SERVE YOU Rx DIRECT

Please print using blue or black ink. **One form per member.**
If you have questions or need additional forms, visit serveyourx.com.

Mail this completed order form with your new prescription(s) to Serve You DirectRx Pharmacy, 10201 W. Innovation Dr., Ste. 600, Milwaukee, WI 53226. Do not staple or tape prescriptions to the order form.

PRESCRIPTION BENEFIT CARDHOLDER INFORMATION

Prescription Benefit Plan Name: _____

Member ID #: _____ Rx Group #: _____ Rx BIN #: _____ PCN: _____

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

Primary Phone #: (_____) _____-_____ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: (_____) _____-_____ ☐ Mobile ☐ Work ☐ Home

MEDICATION ALLERGIES

☐ No known allergies ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Quinolones ☐ Tetracyclines
☐ Amoxil/Ampicillin ☐ Cephalosporins ☐ Erythromycin ☐ Penicillin ☐ Sulfa drugs ☐ Others: _____

HEALTH CONDITIONS

☐ None ☐ Asthma ☐ Epilepsy ☐ High blood pressure ☐ Osteoporosis ☐ Others: _____
☐ Acid Reflux ☐ Depression ☐ Glaucoma ☐ High cholesterol ☐ Prostate issues
☐ Arthritis ☐ Diabetes ☐ Heart problem ☐ Migraine ☐ Thyroid – low/high

Over-the-counter/herbal medications taken regularly: _____

ADDITIONAL PROCESSING INFORMATION

☐ **Enroll prescriptions in EZAutoFill,** a service that automatically ships your medications when they are eligible for refills. There is no cost for this service beyond your medication copay(s). This service is not available to Medicare patients.

☐ **Keep on file.** If you are including any prescriptions that you want keep on file for shipment at a later date, please list them below:
_____
_____
_____

Notes to pharmacy: _____

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost.

PAYMENT & SHIPPING <u>Do not send cash.</u>

☐ **Ship overnight** (Please add $35 to order amount)
☐ **Check** (Payable to: Serve You DirectRx Pharmacy) Total Amount Enclosed: $_____
☐ **Charge to my credit card on file**
☐ **Charge to a NEW credit card:** ☐ Mastercard ☐ VISA ☐ American Express ☐ Discover

Name as it Appears on Credit Card: _____

Billing Address: _____ Billing ZIP Code: _____

Credit Card #: _____–_____–_____–_____ Expiration Date (month/year): ____/_____

Cardholder Signature: _____ Today's Date (month/day/year): ____/____/____

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

Signature: _____ Today's Date (month/day/year): ____/____/____

Standard processing time for orders is 2–3 business days from the date the completed order is received at the pharmacy. Please allow additional time for delivery when placing your order. Serve You DirectRx will contact you if there will be a delay in processing your order. Once shipped, medications may not be returned for a refund or adjustment.