Prescription Transfer Form

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.

If you currently use a mail service or local pharmacy to fill your prescriptions, you can easily transfer them to Serve You Rx Home Delivery Pharmacy by completing this form. An order will be placed for all prescriptions marked "Fill" on page 2.

Mail the completed transfer form along with payment, if applicable, to:
Serve You Rx Home Delivery Pharmacy
10201 West Innovation Drive, Suite 600
Milwaukee, WI 53066

Forms may also be returned via confidential fax to 866-494-0364

PRESCRIPTION BENEFIT CARDHOLDER INFORMATION

Prescription Benefit Plan Name: _____
Member ID #: _____ Group #: _____ 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 ☐ For all orders
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: _____

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

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 Rx Home Delivery Pharmacy 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.

☐ **Ship overnight** (Please add $35 to order amount)
☐ **Check** (Payable to: Serve You Rx Home Delivery Pharmacy) Total Amount Enclosed: $ _____
☐ **Charge 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: _____
Credit Card #: _____ Expiration Date (month/year): _____ CVV: _____
Cardholder Signature: _____ Today's Date (month/day/year): _____

☐ I authorize Serve You Rx 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): _____

TRANSFER MEDICATIONS

Fill out the information on page 2. An order will be placed for all prescriptions marked "Fill" .

PRESCRIPTION TRANSFER INFORMATION

Last Name: ______________________ First Name: ______________________ MI: _____ Gender: ☐ Male ☐ Female

RX #: ________________ **DRUG NAME/STRENGTH:** ______________________________

☐ Fill ☐ Do not fill at this time ☐ Fill and place on EZAutoFill, automatic refill (EZAutoFill is not available to Medicare Patients)

Directions for Use: ____

Prescriber Name: ______________________ Prescriber Phone #: ________________

Pharmacy Name: ______________________ Pharmacy Phone #: ________________

RX #: ________________ **DRUG NAME/STRENGTH:** ______________________________

☐ Fill ☐ Do not fill at this time ☐ Fill and place on EZAutoFill, automatic refill (EZAutoFill is not available to Medicare Patients)

Directions for Use: ____

☐ Prescriber and Pharmacy Information Same as Above

Prescriber Name: ______________________ Prescriber Phone #: ________________

Pharmacy Name: ______________________ Pharmacy Phone #: ________________

RX #: ________________ **DRUG NAME/STRENGTH:** ______________________________

☐ Fill ☐ Do not fill at this time ☐ Fill and place on EZAutoFill, automatic refill (EZAutoFill is not available to Medicare Patients)

Directions for Use: ____

☐ Prescriber and Pharmacy Information Same as Above

Prescriber Name: ______________________ Prescriber Phone #: ________________

Pharmacy Name: ______________________ Pharmacy Phone #: ________________

RX #: ________________ **DRUG NAME/STRENGTH:** ______________________________

☐ Fill ☐ Do not fill at this time ☐ Fill and place on EZAutoFill, automatic refill (EZAutoFill is not available to Medicare Patients)

Directions for Use: ____

☐ Prescriber and Pharmacy Information Same as Above

Prescriber Name: ______________________ Prescriber Phone #: ________________

Pharmacy Name: ______________________ Pharmacy Phone #: ________________

RX #: ________________ **DRUG NAME/STRENGTH:** ______________________________

☐ Fill ☐ Do not fill at this time ☐ Fill and place on EZAutoFill, automatic refill (EZAutoFill is not available to Medicare Patients)

Directions for Use: ____

☐ Prescriber and Pharmacy Information Same as Above

Prescriber Name: ______________________ Prescriber Phone #: ________________

Pharmacy Name: ______________________ Pharmacy Phone #: ________________

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.