Prescription Transfer Form

SERVE YOU Rx DIRECT

Please print using blue or black ink. **One form per member.**

If you currently use a mail service or local pharmacy to fill your prescriptions, you can easily transfer them to Serve You DirectRx Pharmacy by completing this form. An order will be placed for all prescriptions marked "Fill" on page 2. If you have questions or need additional forms, visit serveyourx.com.

Mail the completed transfer form along with payment, if applicable, to Serve You DirectRx Pharmacy (10201 W. Innovation Dr., Milwaukee, WI 53226) or 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

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>

☐ **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

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.

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): _____

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 onEZAutoFill (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 EZAutoFilll (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.