New Prescription Mail-in Order 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.

Do not staple or tape prescriptions to the order form. Mail this completed order form with your new prescription(s) to:
Serve You Home Delivery Pharmacy, 10201 West Innovation Drive, Suite 600, Milwaukee, WI 53066

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: _____

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 to 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>.

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 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 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): _____
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): _____