

For PCS Internal Use Only

Check or Money Order #

Amount

New Rxs

Refills

Operator's Initials

CTC

of Coupons

PCS Mail Service® Order Form

For fast refills, visit our website at
www.pcsRx.com or call 1-800-966-5772

Cardholder Information – Please print within the boxes using black ink.

Cardholder ID # (generally your SSN)

PCS Group # (on your member ID card)

Last Name of Cardholder

First Name of Cardholder

MI

Delivery Address (If you select 2nd Day or Next Day shipping, fill in a street address, not a P.O. Box.)

City

State

Zip

Above delivery address is for: (check only if applicable) this order only permanent address change

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Daytime Phone

Evening Phone

E-mail Address (if available) Providing your e-mail address authorizes PCS to e-mail you information about your PCS Mail Service account.

Doctor's Name

Doctor's Phone

Doctor's Name

Doctor's Phone

Payment Options – Payment to PCS Mail Service is due with each order. Do not send cash. Refer to your benefit materials for copayment amount(s).

Check # _____ Money Order # _____

Check or money order amount \$ _____

Please write your cardholder ID number on your check or money order. There is a \$10.00 returned check charge.

MasterCard VISA American Express Discover

Account # _____ Exp. Date / /
MM YYYY

If you use a credit card for your payment, PCS will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due to PCS.

Cardholder's Signature _____

Delivery Options

Please allow 14 days from the date you mail your order for delivery of your medicine.

Choosing 2nd Day or Next Day delivery affects only shipping time, not the processing time of your order.

Standard Postal (no charge)

2nd Day (\$10.00)

Next Day (\$13.00) (Weekend deliveries not available)

Special Instructions

Prescription Bottle Cap: A child-resistant cap is included with every order. Please check the following box if you would also like an easy-open cap.

¿Quiere las instrucciones en español?
(Spanish label instructions?) Sí/Yes

If you do not want your doctor or prescriber contacted about a clinically appropriate, potentially cost-saving preferred drug, check here:

Health History (Please ✓check all that apply to you, your spouse or covered dependent(s).)

Simply complete information for all covered family members. If you are unsure about any health conditions, check with your doctor. This portion will not be required on subsequent orders unless there have been changes in health or coverage status.

	Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	M / F	No Known Allergy 010000	Penicillin Allergy 031000	Sulfa Allergy 040000	Other Allergy 040000	Diabetes 050000	Thyroid 060000	Heart Condition 100000	High Blood Pressure 120000	Ulcers 181000	Epilepsy 292019	Glaucoma 301000	Other Conditions
Member															
Spouse															
Dependent															
Dependent															
Dependent															
Dependent															

If you have additional dependents or require more space, please attach a separate note.

New Prescriptions – Please enclose your original, written prescription and payment with this form.

Ask your doctor to write a mail order prescription to maximize the supply as allowed by your plan.

Refill Prescriptions – For faster refills, visit www.PcsRx.com or call the toll-free number on your prescription label.

Affix refill label in space below or fill in prescription information. For additional refills, use the Comments section or attach a separate sheet of paper.

Patient's Name _____
 Rx # _____ Drug Name _____
 Doctor's Name _____
 Doctor's Phone # _____

Patient's Name _____
 Rx # _____ Drug Name _____
 Doctor's Name _____
 Doctor's Phone # _____

Comments (Please print clearly)

Authorization and Signature

I authorize the use and release of information to my plan sponsor, plan administrator, health care providers and their agents for use in connection with the management of my health benefits and those of my covered dependents.

 Member's Signature

 Date (MM/DD/YYYY)

PCS Mail Service will substitute an available generic equivalent for certain brand-name drugs whenever allowed by your doctor and applicable pharmacy law. If you do not want a generic substitution for a specific medication, please note in the Comments section. Please check your prescription bottle to identify from which state your prescription was dispensed. If your prescription was dispensed from PCS Mail Service in Ft. Worth, Texas, complaints concerning the practice of pharmacy may be filed with the Texas State Board of Pharmacy at 333 Guadalupe Street, Box 21, Austin, TX 78701-3942, or by calling (512) 305-8000 or 800-821-3205.