



# Medco Health Home Delivery Pharmacy Service™ Order Form



BLUE CROSS

## For All Home Delivery Orders

Place all prescriptions and refill slips together with this completed order form and your copayment in the enclosed return envelope. Be sure to fold the form as indicated so the address on the bottom right shows through the window.

## For New Prescriptions

Fill out one line of the Patient Information Section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number. **Your Home Delivery cost share applies regardless of the size of your prescription. To optimize your benefit, prescriptions should be written for up to the supply maximum allowed by your Plan.**

## For Refills

To order on the Internet: Visit **MyPharmacyPlus** through the Pharmacy section at [www.premera.com](http://www.premera.com). Have your Member ID number and Prescription (Rx) number on hand. Your 12-digit Prescription or Rx number can be found on your refill slip.

To order by phone: Call **1-800-4REFILL** (1-800-473-3455) to use the automated refill system. Have your Member ID number and your refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

## If You Need Additional Help

Call Medco Health Member Services at **1-800-391-9701**. They are open 24 hours a day, 7 days a week except Thanksgiving & Christmas. See the back of this form for additional instructions.

## Subscriber Information (See your ID card)

Identification #: \_\_\_\_\_  
*(Please complete. Do not use Social Security Number.)*

Rx Group #: \_\_\_\_\_

Employer Group Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Daytime telephone \_\_\_\_\_

Evening telephone \_\_\_\_\_

## Shipping address if different from your mailing address

Check if  Temporary  Permanent

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Patient Information—Complete one line for each new prescription (Do not complete for refills)

Patient name and Medicare B number (if applicable)	Patient's relation to Plan Subscriber (fill in one)	Gender	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

## Order Information

Total number of medications in this order (including all refills and new medications)

Subtotal of this order \$ .

Optional expedited shipping \$9.00 (subject to change) .

Total enclosed (do not send cash) \$ .

Paying by Credit Card?  Visa  MC  Disc/NOVUS  AmEx  Diners

CREDIT CARD NUMBER

M   Y

EXPIRATION DATE

CARDHOLDER SIGNATURE

X

Check here to have all orders billed to your credit card.

By doing so, you authorize Medco Health to keep your card number on file and bill all future orders directly to your credit card. To enroll by phone, please call 1-800-948-8779.

Paying by check? Write your Member ID # on your check or money order made payable to Medco Health.

MEDCO HEALTH  
PO BOX 3938  
SPOKANE WA 99220-3938



FOLD BACK HERE

FOLD BACK HERE

**Please take a minute to make sure...**

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your Member ID on any check or money order.**
- **The Medco Health address on the front shows through the window of the return envelope.**
- **When you start Home Delivery Pharmacy Service, you will receive a Health, Allergy, and Medication Questionnaire. This information will help Medco Health better serve your prescription drug needs.**

**Expedited shipping available**

For an additional fee, your order will be shipped by an expedited service if offered to your area. This option must be chosen when you make the order, and cannot be applied after an order is already processed.

**Additional Instructions**

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all Home Delivery Pharmacy Service orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If you do, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance is paid.

You can call 1-800-948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

**Get more information from MyPharmacyPlus**

Visit **MyPharmacyPlus** through the Pharmacy section at [www.premera.com](http://www.premera.com).

