



Medco Health Home Delivery Pharmacy Service™ Order Form



Benefits Provided by Educators Mutual

For Refills

To order from our website: www.medcohealth.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.

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.

For All Home Delivery Orders

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

If You Need Additional Help

Call Member Services at **1 800 316-9176**. Best times to call are Tuesday through Friday afternoons.

See the back of this form for additional instructions.

Member Information

Member ID:

Group: **EMIARXD**

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime telephone

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Evening telephone

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Shipping address if different from your mailing address

Check if Temporary Permanent

You authorize release of all information to the plan administrator, sponsor, or their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of you or your family members.

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 member (fill in one)	Sex	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

X _____
CARDHOLDER SIGNATURE

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.

Please be sure address is visible through window of return envelope

**MEDCO HEALTH
PO BOX 30493
TAMPA, FL 33630-3493**



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.**
- **You have filled out the 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 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.

Florida Law requires pharmacists to substitute a less expensive, generically equivalent drug for certain brand name drugs unless you or your physician direct otherwise.

Get more information from our website.

Visit us at www.medcohealth.com.