

MLRIMGPTM JAB9372 REV 01/06/2006



ANCHOR/PMD

UPMC HEALTH PLAN
Where you belong.



Postage
Required
Post Office will
not deliver
without proper
postage



EXPRESS SCRIPTS®

HOME DELIVERY SERVICE
PO BOX 847
BENSALEM PA 19020-0847



NEW PATIENT HOME DELIVERY FORM

Please complete all portions of this form by printing in **ALL CAPITAL LETTERS** using **black ink**. If there are more than three (3) family members, write the information on a separate piece of paper.

1. PERSONAL INFORMATION

Cardholder ID Number

(Refer to your Plan card)

Cardholder First Name

M.I. Last Name

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)

Tetracycline (07) Erythromycin (09) Other:

No Known Drug Allergies (00)

Birth Date

- -

Gender

Provide a street address. Certain medications cannot be delivered to a post office box.

Mailing
Address

City

State

ZIP Code

-

Phone #

- -

Your phone number is used to provide information about your order.

Physician Last Name

Physician Phone #

Family Member 1 First Name

M.I. Last Name

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)

Tetracycline (07) Erythromycin (09) Other:

No Known Drug Allergies (00)

Birth Date

- -

Gender

Physician Last Name

Physician Phone #

Family Member 2 First Name

M.I. Last Name

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)

Tetracycline (07) Erythromycin (09) Other:

No Known Drug Allergies (00)

Birth Date

- -

Gender

Physician Last Name

Physician Phone #

FOLD HERE ↓

FOLD HERE ↓

Family Member 3 First Name

M.I. Last Name

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)

Tetracycline (07) Erythromycin (09) Other:

No Known Drug Allergies (00)

Birth Date

- -

Gender

Physician Last Name

Physician Phone #

- -

2. PAYMENT INFORMATION

Include payment with your order. **DO NOT SEND CASH.**
Standard delivery of your order is **FREE** and should arrive within 14 days from the date we receive your order.



ANCHOR/PMD

NOTE: Your check card or credit card will be charged according to your prescription plan. All orders will be charged to this card, unless payment (check or money order) accompanies the order.

Check Card

Credit Card

Card #

Expiration Date

-

Cardholder Name

x

AUTHORIZED SIGNATURE

Print name as it appears on card

NOTE: If paying by check or money order, please refer to your prescription plan materials for copy.

Check/Money Order

Amount Enclosed \$

3. SIGNATURE REQUIRED

Check any options that apply and sign the following statement.

I prefer non-child resistant (easy open) caps.

I request that this and future orders be shipped "signature required" for an additional charge.

I certify that all the information on this form is correct, including any selections made for sending my order "signature required" or for non-child resistant (easy open) caps. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment, or health care operations.

x

SIGNATURE REQUIRED

4. REMINDER

- Make sure the following information is clear and easy to read on your prescription:
 - Doctor Information:** Name, Signature, and DEA Number. If there are multiple doctors, circle your doctor's name.
 - Patient Information:** First and Last Name, Address, Date of Birth, and ID Number.
 - Prescription Information:** Date Written, Drug Name and Strength, Medication Directions, Medication Quantity, and Number of Refills.
- Prescriptions that do not include this information may be returned to you unfilled.
- FDA approved generic medications will be dispensed when allowed by your physician, subject to the terms outlined in your plan.

QUESTIONS ABOUT YOUR PHARMACY BENEFIT?

TOLL-FREE: 877-787-6279 HEARING IMPAIRED(TDD): 800-899-2114

FOLD HERE

FOLD HERE