

# HOME DELIVERY ORDER FORM



EXPRESS SCRIPTS®



## 1 Member information: Please verify or provide member information below.

**Member ID:** \_\_\_\_\_

**Group:** \_\_\_\_\_

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

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

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

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

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

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

@ \_\_\_\_\_

☐ New shipping address:

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: \_\_\_\_\_

Evening phone: \_\_\_\_\_

## 2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

## 3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders payable to Express Scripts, and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order: \_\_\_\_\_

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

### For credit card payments:

☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number

Expiration date

**X**

Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment (\$21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

Patient/doctor information continued

|                         |  |  |  |  |     |   |  |                                  |  |  |             |  |                       |  |  |  |  |  |  |  |  |
|-------------------------|--|--|--|--|-----|---|--|----------------------------------|--|--|-------------|--|-----------------------|--|--|--|--|--|--|--|--|
| First name              |  |  |  |  |     |   |  |                                  |  |  | Last name   |  |                       |  |  |  |  |  |  |  |  |
| Birth date (MM/DD/YYYY) |  |  |  |  | Sex | <input type="checkbox"/> M <input type="checkbox"/> F |  | Patient's relationship to member | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent |  |             |  |                       |  |  |  |  |  |  |  |  |
| Doctor's last name      |  |  |  |  |     |   |  |                                  |  |  | 1st initial |  | Doctor's phone number |  |  |  |  |  |  |  |  |

|                         |  |  |  |  |     |   |  |                                  |  |  |             |  |                       |  |  |  |  |  |  |  |  |
|-------------------------|--|--|--|--|-----|---|--|----------------------------------|--|--|-------------|--|-----------------------|--|--|--|--|--|--|--|--|
| First name              |  |  |  |  |     |   |  |                                  |  |  | Last name   |  |                       |  |  |  |  |  |  |  |  |
| Birth date (MM/DD/YYYY) |  |  |  |  | Sex | <input type="checkbox"/> M <input type="checkbox"/> F |  | Patient's relationship to member | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent |  |             |  |                       |  |  |  |  |  |  |  |  |
| Doctor's last name      |  |  |  |  |     |   |  |                                  |  |  | 1st initial |  | Doctor's phone number |  |  |  |  |  |  |  |  |

Important reminders and other information

**Check** that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

**Complete** the Health, Allergy & Medication Questionnaire.

**There may be a limit to the balance** that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

**If you are a Medicare Part B beneficiary AND have private health insurance**, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

**Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.**

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

**Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

**For additional information** or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

*Federal law prohibits the return of dispensed controlled substances.*

Place your prescription(s), this form, and your payment in an envelope. Do not use staples or paper clips.

EXPRESS SCRIPTS  
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