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	mail this form to:
Manch on ID # (if not also over on if different from also over)	- - - - - - - - - - - - -
Member ID # (if not shown or if different from above)	
Prescription Plan Sponsor or Company Name	
Instructions: Please use blue or black ink and print in capital let	tters. Fill in both sides of this form.
New Prescriptions - Mail your new prescriptions with	n this form. Number of New prescriptions:
Refills - Order by web, phone, or write in Rx number(s TO RECEIVE YOUR ORDER SOONER request refill website/phone number on your member ID card.	•
A Shipping Address. To ship to an address different	from the one printed above, enter the changes here.
Last Name	First Name MI Suffix (JR, SR)
Street Address	Apt./Suite # Use shipping address for this order only.
City Daytime Phone #:	State ZIP Code Evening Phone #:
B Refills. To order mail service refills, enter your pre	scription number(s) here.
1)2)	3)4)
5) 6)	7)
Log in to check order status and access personalized getting a new prescription, be sure to ask your doctor plan, usually a 90-day supply. Make sure your doctor to provide you with high quality medicines at the besequivalent generic medicines for brand name medicines.	d information about your prescription benefits. When or to write it for the maximum amount allowed by your r SIGNS and DATES all new prescriptions. We want t possible price. In order to do this, we will substitute
We may package all of these prescriptions together unless you tell us	not to.



First person with a refill or new prescription. Last Name Fi	○ Spanish forms and label
Nickname	Suffix (JR,SR)
	Date of birth: //M-DD-YYYY
E-mail address:	Date new prescription written:
Doctor's last name Doctor's first na	ame Doctor's phone #
Tell us about new health information for 1st person i Allergies: None Aspirin Cephalosporin Sulfa Other:	
Medical conditions: () Arthritis () Asthma () Diabete () High blood pressure () High cholesterol () Migr () Other:	
Second person with a refill or new prescription.	○ Spanish forms and label
Nickname	Date of birth: //M-DD-YYYY
E-mail address:	Date new prescription written:
Doctor's last name Doctor's first na	ame Doctor's phone #
Other:	Codeine Cerythromycin Peanuts Penicilli
○ High blood pressure ○ High cholesterol ○ Migr	es () Acid reflux () Glaucoma () Heart problem raine () Osteoporosis () Prostate issues () Thyroic
() Otner:	
Special instructions:	
Special instructions:	pay is \$0, you do not need to provide payment information.
Special instructions:	pay is \$0, you do not need to provide payment information.
Special instructions:	pay is \$0, you do not need to provide payment information. ou must first register online or call Customer Care.)
How would you like to pay for this order? (If your continuous Electronic check. Pay from your bank account. (You Credit or debit card. (VISA®, MasterCard®, Discovery Use your card on file. Use a new card or update your card's expiration of	pay is \$0, you do not need to provide payment information. ou must first register online or call Customer Care.) er®, or American Express®)
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