

Mail Service Prescription Order Form

PBM Plus Mail Service Pharmacy

An Omnicare Company

INSTRUCTIONS

1. Complete all applicable sections on this form. To prevent a delay in processing your order, **please print clearly**
- Use a separate Order Form for each patient**
2. Highlight any changes (i.e. address, telephone, etc.)
3. List health conditions on a separate page.
4. Verify that all applicable sections requiring a signature have been signed.
5. Tear along dashed line to separate envelope, then tear off this stub.
6. Place this Order Form, any new prescriptions, any additional paperwork and check or money order (if not paying by credit card) into the attached envelope and seal.
7. If the envelope is missing, address an envelope to:
**PBM Plus MSP
300 TechneCenter Drive Suite C
Milford, OH
45150**
Be sure to include your return address.
8. Attach appropriate postage and mail.
9. Allow ten to fourteen days for your order to arrive at your door.

I. MEMBER INFORMATION: PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH ORDER

Member's Name: _____ Date of Birth: _____ Gender: _____
First M.I. Last MM DD YYYY M/F

Member's Address: _____ (_____) _____ - _____
Street Apt Number Area Code Phone Number

City State Zip Code E-mail address: _____

Check if this is a permanent change of address Check if this is a temporary address for this order only

Please check this box and sign below if you do not want child-proof caps (By requesting easy open caps, I acknowledge and agree to release PBM Plus, Inc from any and all obligations and liabilities related to not providing child resistant packaging under the Poison Prevention Act.)

Signature: X _____

II. PAYMENT INFORMATION: Please indicate how you will be paying for this order

Check or money order – amount: \$ **Discover** **Master Card** **VISA**

Please complete the following information if you are paying by credit card **Cardholder's Name:** _____
Card Number: _____ **Exp. Date:** _____

I authorize PBM PLUS, Inc. to charge to the credit card indicated above all charges pertaining to the new and/or refill prescription requests included with this form. I attest that I am a legal, authorized user of the designated card. I further agree that I will make all necessary payments to my credit card per my cardholder agreement. Charges made to my credit card will appear on my credit card statement as "PBM Plus, Inc."

Signature: X _____

III. INSURANCE INFORMATION: If your prescription is covered by a pharmacy benefit plan please complete this section.

Member ID No: _____ **Plan Sponsor:** _____ **Group Number:** _____

All of the above information is found on your ID card

Certification Statement: I certify that the Member Information entered on this form is correct and I am eligible for benefits under the Prescription Drug Program indicated above. I hereby assign to PBM Plus, Inc. any payments due as a result of this transaction and authorize payment directly to PBM Plus, Inc. I also authorize release of all information pertaining to my claims(s) for prescription drugs to PBM Plus, Inc. and its designees.

Signature: X _____ **Date:** _____

IV. REFILL PRESCRIPTION INFORMATION

Please apply the bar code label from you last order or list the prescription number(s) and the name of the medication you are ordering in the spaces below. The name of the medication can be found on your bottle label.

Rx#: _____ **Rx Name:** _____

Rx#: _____ **Rx Name:** _____

Rx#: _____ **Rx Name:** _____

Rx#: _____ **Rx Name:** _____

V. MEDICAL HISTORY INFORMATION

COMPLETE THIS SECTION WHEN PLACING YOUR FIRST ORDER OR SHOULD YOUR MEDICAL HISTORY CHANGE.

Physician's Name: _____ **Physician's Phone:** (_____) _____

Please list any health conditions, drug allergies, or other medications you are taking in the space below or on a separate page

Patient	Name	Sex	Date of Birth	Drug Allergies* see below for codes						Current Medications or Other Allergies
				None	01	03	04	15	99	
Cardholder										
Spouse										
Dependent 1										
Dependent 2										
Dependent 3										

Allergies: 01 Penicillin 03 Aspirin 04 Codeine 15 Sulfa 99 Other Allergy – Please List