Q54PPM.MSF (11/08/01)

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

Q54 **ANCHOR/Q54**

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 454 BENSALEM, PA

POSTAGE WILL BE PAID BY ADDRESSEE

EXPRESS SCRIPTS®
MAIL PHARMACY SERVICE
PO BOX 8545
BENSALEM, PA 19020-8545

EXPRESS SCRIPTS®
Charting the Future of Pharmacy
www.express-scripts.com

Refer to Member Handbook for Commonly Asked Questions

Mail Service Benefits

- Free delivery (standard postage)
- Convenient home delivery in 14 days
- Free Drug Interaction screening
- Pharmacist available 24 hours
- 24-hour touch-tone service available for refills or to check status on refills
- VISA, MC, DISCOVER and AMERICAN EXPRESS

Customer Service

1-800-550-8090

www.express-scripts.com

PLEASE ALLOW 2 WEEKS FOR DELIVERY

Hearing Impaired:
TDD# 1-800-899-2114

PLEASE PRINT **Complete all sections to order your medications** MOISTEN, FOLD OVER AND SEAL

ANCHOR/Q54

I.D. Number _____

Group/Employer Name_____

COMPLETE FORM TO ORDER - You only need to complete this section for a covered family member the first time the person orders medication, unless any information changes.

MEMBER

Last name_____ (Jr., Sr., III) _____

First Name _____ Middle Initial _____

Nickname _____ Gender _____

Birthdate (mo/day/yr) _____

Health Conditions

- ❑ Asthma (493.90)
- ❑ Arthritis (714.0)
- ❑ Diabetes (250.01)
- ❑ Depression (311)
- ❑ Glaucoma (365.9)
- ❑ High Cholesterol (272.0)
- ❑ Hypertension (402.90)
- ❑ Thyroid
  - ❑ High (242.9) ❑ Low (244.9)

Drug Allergies

- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

List Other conditions and allergies: _____

_____

Prescribing Physician

Last name_____ First Name _____

Phone (_____) _____

DEPENDENT #1 ❑ SPOUSE ❑ CHILD

Last name_____ (Jr., Sr., III) _____

First Name _____ Middle Initial _____

Nickname _____ Gender _____

Birthdate (mo/day/yr) _____

Health Conditions

- ❑ Asthma (493.90)
- ❑ Arthritis (714.0)
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_____

Prescribing Physician

Last name_____ First Name _____

Phone (_____) _____

TO ORDER: Enclose your original written prescription(s). If you are already taking a medication, call your doctor and request a new prescription for the maximum days supply allowed by your plan.

SHIP TO: ❑ Check here for a temporary address change
Temporary Address Start Date: _____ End Date: _____

❑ Check here for a permanent address change and enter it below

Name _____

Mailing Address _____

_____ Apt. or Suite _____

City_____ State ____ Zip _____

How to contact you if we have questions

	Day	Night
Home Phone (___) _____	❑	❑
Work Phone (___) _____	❑	❑
Cell Phone (___) _____	❑	❑
Pager (___) _____	❑	❑

e-mail _____

I prefer large print ❑ Yes ❑ No

I prefer "easy open" caps ❑ Yes ❑ No

We will dispense FDA approved generic medications when allowed by your physician, subject to the terms outlined in your plan. *To avoid delay please enclose check, money order or credit card information if any payment is due.

METHOD OF PAYMENT (Please do not send cash)

No payment is due for a Workers' Compensation claim.

❑ Check #_____ Amount _____

❑ Money Order or Cashier's Check Amount _____
Payable to Express Scripts

NOTE: All prescriptions, invoices and statements are sent in the name of the subscriber.

❑ Charge this and all future orders to this credit card

❑ Charge to my credit card

❑ VISA ❑ MasterCard ❑ Discover ❑ American Express

❑ I request this and all future orders be shipped "signature required". I understand there will be an extra charge for this service.

Credit Card # _____ Exp. Date_____

Signature _____