

(Serve you.)

DIRECTRx PHARMACY

Prescription Order Form

CUSTOMER SERVICE: 800-759-3203

Monday – Friday 7:30 a.m. to 9:00 p.m. CST

Saturday 8:00 a.m. to 6:00 p.m. CST

Sunday 9:00 a.m. to 3:00 p.m. CST

www.serve-you-rx.com

FOR INTERNAL USE ONLY

OF NEW PRESCRIPTIONS

OPERATOR'S INITIALS

ORDER #

CHECK/MONEY ORDER #

AMOUNT

COUPON AMOUNT



*Please allow 5-7 business days
to receive your prescription*

MAIL COMPLETED FORM TO: Serve You DirectRxSM Pharmacy,
P.O. Box 26096, Milwaukee, WI 53226

Primary member information (please print)

Employer/Health Plan Name: _____

ID#: _____ Group #: _____

Last Name: _____ MI: _____ First Name: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Temporary or Alternate Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Email Address: _____

Providing your email address and phone number authorizes us to contact you about your account or our services. Your phone and email information will not be shared with any outside party. Please note: Other household members using this email address may be able to access your health information.

Payment options (payment must accompany each order)

**AMOUNT
ENCLOSED**

**METHOD OF
PAYMENT**

Check (*payable to: Serve You Custom Prescription Management*) Money Order

MasterCard VISA American Express Discover

Yes, please keep this credit card on file and use for future Serve You DirectRx Pharmacy purchases.

To authorize payment by credit card, please provide the account number, expiration date and cardholder's signature.

Credit Card #: _____ Expiration Date (month/year): _____ / _____

Cardholder Signature: _____ Today's Date (month/day/year): _____ / _____ / _____

Certification: I certify that the information on this form is correct and further understand that any benefits are subject to my eligibility for and participation in the medical plan, and certify that I or my dependents for whom prescriptions are enclosed do not have primary prescription drug coverage under any other medical plan.

NOTE: All communications, including mailed prescriptions, will be directed to the primary member on the Enrollment Form. A covered dependent who wishes to receive communications directly should include a request in writing with any prescription order.

Signature: _____ Date (month/day/year): _____ / _____ / _____

Patient #1 information

Last Name: _____ MI: _____ First Name: _____

Birth Date: _____ / _____ / _____

Self Spouse Dependent Female Male Email Address: _____

DRUG ALLERGIES:

None Aspirin Codeine Penicillin Sulfonamides Iodine Erythromycin Other: _____

HEALTH CONDITIONS: (to determine drug/disease interactions)

Asthma Diabetes High Blood Pressure High Cholesterol Depression Arthritis Thyroid – Low/High

Ulcer Glaucoma Other: _____

List other prescription/non-prescription drugs being taken: _____

Physician's Name: _____ Physician's Phone #: _____

Patient #2 information

Last Name: _____ MI: _____ First Name: _____

Birth Date: _____ / _____ / _____

Self Spouse Dependent Female Male Email Address: _____

DRUG ALLERGIES:

None Aspirin Codeine Penicillin Sulfonamides Iodine Erythromycin Other: _____

HEALTH CONDITIONS: (to determine drug/disease interactions)

Asthma Diabetes High Blood Pressure High Cholesterol Depression Arthritis Thyroid – Low/High

Ulcer Glaucoma Other: _____

List other prescription/non-prescription drugs being taken: _____

Physician's Name: _____ Physician's Phone #: _____

Patient #3 information

Last Name: _____ MI: _____ First Name: _____

Birth Date: _____ / _____ / _____

Self Spouse Dependent Female Male Email Address: _____

DRUG ALLERGIES:

None Aspirin Codeine Penicillin Sulfonamides Iodine Erythromycin Other: _____

HEALTH CONDITIONS: (to determine drug/disease interactions)

Asthma Diabetes High Blood Pressure High Cholesterol Depression Arthritis Thyroid – Low/High

Ulcer Glaucoma Other: _____

List other prescription/non-prescription drugs being taken: _____

Physician's Name: _____ Physician's Phone #: _____