

# (Serve you.)

THE HAND-CRAFTED PBM

## Prescription Order Form

**Member Services: 1.800.759.3203**

**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 2 WEEKS FOR RECEIPT OF YOUR PRESCRIPTION(S)**

### Member Information (Please print.)

Employer/Health Plan Name: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Temporary or Alternate Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

E:Mail: \_\_\_\_\_

### 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

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

Yes, please keep this credit card on file and use for future purchases.

Credit Card #:     -     -     -     Exp. Date:   -      
(Month) (Year)

Cardholder Signature: \_\_\_\_\_

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. I also agree to reimburse the plan sponsor to the extent of any benefit which is in excess of the amount payable under the 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: \_\_\_\_\_

## Patient #1 Information

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Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Self  Spouse  Dependent  Female  Male

**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

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Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Self  Spouse  Dependent  Female  Male

**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

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Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Self  Spouse  Dependent  Female  Male

**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 #: \_\_\_\_\_

Mail completed form to: Serve You DirectRx Pharmacy, P.O. Box 26096, Milwaukee, WI 53226

**Member Services: 1.800.759.3203 [www.serve-you-rx.com](http://www.serve-you-rx.com)**