SERVE YOU Rx DIRECT

Prescription Transfer Form

If you currently use a mail service or local pharmacy to fill your prescriptions, you can easily transfer them to Serve You DirectRx℠ Pharmacy by completing this form. An order will be placed for all prescriptions marked "Fill" on page 2. Questions can be directed to Customer Service at **800-759-3203**.

MAIL OR FAX COMPLETED FORM TO:
Serve You DirectRx Pharmacy
P.O. Box 26096
Milwaukee, WI 53226
FAX 866-494-0364

INSTRUCTIONS: Complete page 1 and the "Prescription Transfer Information" on page 2. Mail or fax both pages of this completed transfer form along with payment, if applicable.

For additional forms, visit serve-you-rx.com.

Please print

CARDHOLDER INFORMATION ☐ Establish an account* (see NOTE)

Employer/Health Plan Name: _____

Member ID #:_____ Group #:_____ Gender: ☐ Male ☐ Female

Last Name: _____ First Name: _____ MI: _____

Permanent Address: _____City:_____ State: _____ ZIP: _____

Delivery Address:_____City:_____ State: _____ ZIP: _____

(If different than the permanent address) ☐ For this order only

Primary Phone #: (_____) _____-_____ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: (_____) _____-_____ ☐ Mobile ☐ Work ☐ Home

Email Address: _____

METHOD OF PAYMENT

☐ **Check or Money Order:** (Payable to: Serve You DirectRx Pharmacy) **Total Amount Enclosed: $**_____

To authorize payment by credit card, please provide following information:

☐ **Use Credit Card On File:** Last four digits of card on file: _____

☐ **Credit Card:** ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Name as it Appears on Credit Card: _____ Billing ZIP Code: _____

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

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

☐ I authorize Serve You DirectRx Pharmacy to maintain my credit card on file as payment method for any future charges. I understand that all prescription orders requested by me or new prescriptions provided to Serve You DirectRx Pharmacy by my physician will automatically be processed and shipped using this card for payment.

Certification and Authorization: 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. I 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 cardholder. A covered dependent who wishes to receive communications directly should include a request in writing with any prescription order.*

*For each account, all prescriptions ordered are sent in separate packages.

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

Prescription Transfer Information Please print

PATIENT #1 INFORMATION: ☐ Self ☐ Spouse ☐ Dependent

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ Male ☐ Female
Date of Birth: _____/_____/_____ Email Address: _____

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

PATIENT #2 INFORMATION: ☐ Self ☐ Spouse ☐ Dependent

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ Male ☐ Female
Date of Birth: _____/_____/_____ Email Address: _____

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

PATIENT #3 INFORMATION: ☐ Self ☐ Spouse ☐ Dependent

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ Male ☐ Female
Date of Birth: _____/_____/_____ Email Address: _____

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time

Rx#: _____ Drug Name/Strength: _____ ☐ Fill
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____-_____ ☐ Do Not Fill At This Time