WI ETF New Prescription Mail-in Order Form

Please print using blue or black ink. ***One form per member.***

Mail this completed order form with your new prescription(s) to Serve You DirectRx Pharmacy, P.O. Box 26096, Milwaukee, WI 53226. Do not staple or tape prescriptions to the order form.

MEMBER INFORMATION

Member ID #:____________________ Group #:____________________

Last Name: ____________________ First Name: ____________________ MI: __________

Delivery Address: ______________________________ Apt. #:__________

City:____________________ State:______ ZIP:______________ Primary Phone #: (_____) _____-_________

Date of Birth (mm/dd/yy): _____ /_____ /_____ Gender: ☐ Male ☐ Female Email: ______________________________

MEDICATION ALLERGIES

☐ No known allergies ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Quinolones ☐ Tetracyclines
☐ Amoxil/Ampicillin ☐ Cephalosporins ☐ Erythromycin ☐ Penicillin ☐ Sulfa Drugs ☐ Others: ____________________

HEALTH CONDITIONS

☐ None ☐ Asthma ☐ Epilepsy ☐ High blood pressure ☐ Osteoporosis ☐ Others: ____________________
☐ Acid Reflux ☐ Depression ☐ Glaucoma ☐ High cholesterol ☐ Prostate issues
☐ Arthritis ☐ Diabetes ☐ Heart problem ☐ Migraine ☐ Thyroid – low / high

Over-the-counter/herbal medications taken regularly: ______________________________

ADDITIONAL PROCESSING INFORMATION

Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:____________________
____

Notes to pharmacy: ______________________________

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. **Brand-name medications may be subject to a higher cost.**

PAYMENT & SHIPPING

Standard processing time for orders is 2–3 business days from the date the completed order is received at the pharmacy. Please allow additional time for delivery when placing your order. *DirectRx Pharmacy* will contact you if there will be a delay in processing your order. Once shipped, medications may not be returned for a refund or adjustment.

Do not send cash.

☐ **Ship overnight** (Please add $35 to order amount)
☐ **Check** (Payable to: Serve You DirectRx Pharmacy) Total Amount Enclosed: $_______
☐ **Charge to my credit card on file**
☐ **Charge to a NEW credit card:** ☐ Mastercard ☐ VISA ☐ American Express ☐ Discover

Name as it Appears on Credit Card: ______________________________
Billing Address: ______________________________ 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 this NEW credit card on file and use as payment for future charges.*

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

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