WI ETF Prescription Transfer Form

SERVE YOU Rx DIRECT

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

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 **800-481-4940**.

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.

CARDHOLDER INFORMATION

Employer/Health Plan Name: _____

Member ID #:_____ Group #:_____ Date of Birth: ____/____/____ 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: _____

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)*: ____/____/____

PRESCRIPTION TRANSFER PATIENT INFORMATION

Last Name: ____________________________ First Name: ___________________________ MI: _____ Gender: ☐ Male ☐ Female

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

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

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.**