

New Prescription Mail-in Order Form



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

If you have questions or need additional forms, visit serveyourx.com.

Mail this completed order form with your new prescription(s) to Serve You DirectRx Pharmacy, 10201 W. Innovation Dr., Ste. 600, Milwaukee, WI 53226. Do not staple or tape prescriptions to the order form.

PRESCRIPTION BENEFIT CARDHOLDER INFORMATION

Prescription Benefit Plan Name: _____

Member ID #: _____ Group #: _____ BIN #: _____ PCN: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Gender: Male Female Email Address: _____

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

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

Enroll prescriptions in EZAutoFill, a service that automatically ships your medications when they are eligible for refills. There is no cost for this service beyond your medication copay(s). This service is not available to Medicare patients.

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

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 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

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. Serve You DirectRx 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.

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 to use as payment for future charges.

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