

Medco By Mail ORDER FORM



1 Customer information: Please verify or provide customer information below.

Subscriber #: _____

Rx Grp #: **UHEALTH**

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime phone:

Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: _____@_____.

New shipping address: _____

(Medco will keep this address on file for all orders from this subscriber until another shipping address is provided by any person in this plan.)

Evening phone:

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

First name

Last name

Birth date (MM/DD/YYYY)

Sex
 M F

Patient's relationship to subscriber
 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex
 M F

Patient's relationship to subscriber
 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Medco Health Solutions, Inc.**, and write your subscriber ID number on the front. You can enroll for e-check payments and price medications at **www.myuhc.com**, or call **1-800-948-8779**.

Number of prescriptions sent with this order:

Payment options: e-check Payment enclosed Credit card Send bill

For credit card payments:

Visa MC Discover AmEx Diners

Expiration date

M M Y Y

Cardholder signature

Credit card number

I authorize Medco to charge this card for all orders from any person in this plan.

Rush the mailing of this shipment (\$15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to subscriber

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to subscriber

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail order copayment regardless of the days' supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with three refills.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Customer Care number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1-800-MEDICARE (1-800-633-4227).

Automatic generic equivalent substitution of certain brand-name medications is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want** the generic medication. This applies only to the prescription medication(s) on this order.

Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your doctor direct otherwise. **Check the box if you do not wish a less expensive brand or generic medication "product."** Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information or help, visit us at www.myuhc.com or call the Customer Care number on your ID card. TTY/TDD users should call 1-800-759-1089.

Mailing instructions: Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P.O. BOX 747000
CINCINNATI OH 45274-7000



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