

**HOME DELIVERY  
ORDER FORM**



EXPRESS SCRIPTS®



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**1 Member information:** Please verify or provide member information below.

**Member ID:** \_\_\_\_\_

**Group:** \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

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 member

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 member

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 Express Scripts, and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

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

Credit card number

[ ]

Expiration date

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

M M Y Y

**X**

Cardholder signature \_\_\_\_\_

I authorize Express Scripts to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment (\$21, 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 member

 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 member

 Self  Spouse  Dependent

Doctor's last name

1st initial

Doctor's phone number

**Important reminders and other information**

**Check** that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

**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 prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

**Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.**

Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

**Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

**For additional information** or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

*Federal law prohibits the return of dispensed controlled substances.*

Program: <<XXXXXXXXXX>>



Place your prescription(s), this form, and your payment in an envelope. Do not use staples or paper clips.

EXPRESS SCRIPTS  
PO BOX 66567  
ST. LOUIS, MO 63166-6567



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