


	<p>Mail this form to:</p> <p style="text-align: center;">  IngenioRx Home Delivery PO BOX 94467 PALATINE, IL 60094-4467 </p>
Member ID # (if not shown or if different from above) <input style="width: 100%; height: 20px;" type="text"/>	
Prescription Plan Sponsor or Company Name <input style="width: 100%; height: 20px;" type="text"/>	

Instructions:

Please use **blue or black ink** and **print in capital letters**. Fill in **both sides** of this form.

New Prescriptions – Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills – Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online or by phone at the website/phone number on your member ID card.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name <input style="width: 100%; height: 20px;" type="text"/>	First Name <input style="width: 100%; height: 20px;" type="text"/>	MI <input style="width: 20px; height: 20px;" type="text"/>	Suffix (JR, SR) <input style="width: 100%; height: 20px;" type="text"/>
Street Address <input style="width: 100%; height: 20px;" type="text"/>	Apt./Suite # <input style="width: 100%; height: 20px;" type="text"/>	<input type="radio"/> Use shipping address for this order only.	
City <input style="width: 100%; height: 20px;" type="text"/>	State <input style="width: 20px; height: 20px;" type="text"/>	ZIP Code <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
Daytime Phone #: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Evening Phone #: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>		

B Refills. To order mail service refills, enter your prescription number(s) here.

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

Log in to check order status and access personalized information about your prescription benefits. When getting a new prescription, be sure to ask your doctor to write it for the maximum amount allowed by your plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions. We want to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.



Please fold here →

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C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

First person with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other: _____

Second person with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other: _____

D Special instructions: _____

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

Electronic check. Pay from your bank account. (You must first register online or call Customer Care.)

Credit or debit card. (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER

Exp. Date MMY Y

Check or money order. Amount: \$ _____ . _____

- Make check/money order out to IngenioRx Home Delivery.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

Payment for balance due and future orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

49-MOF 0316 INGENIORX

Credit card holder signature/Date

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

2nd business day (\$17)

Faster delivery can only be sent to a street address, not a PO Box

Next business day (\$23)

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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