



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

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

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

Date of Birth:         Gender:  M  F

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Daytime phone:

Please send me e-mail notices about the status of the enclosed prescription(s) and online orders 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:

FOLD HERE

**2 Member/Doctor information** If you have more than one prescription from the same doctor, complete just one section but include all prescriptions in the envelope provided. If you have prescriptions from more than one doctor, complete a new section for each doctor and include all prescriptions.

Doctor's last name                      1st initial  Doctor's phone number

Doctor's last name                      1st initial  Doctor's phone number

Doctor's last name                      1st initial  Doctor's phone number

Doctor's last name                      1st initial  Doctor's phone number

FOLD HERE

**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 at <http://www.Express-Scripts.com>, or call the Customer Service phone number on your Member 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

Expiration date

M M Y Y

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

Credit card number

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

Rush this shipment (\$15, subject to change). **Note:** This will **not** rush prescription processing. (Street address required; P.O. Box not allowed)

N00SCS3A

**Mailing instructions are provided on the back of this form.**

## 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 the Customer Service phone number on your Member ID card. To verify Medicare Part B prescription coverage, call Medicare at **1-800-MEDICARE (1-800-633-4227)**, which is available 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

**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 **<http://www.Express-Scripts.com>** or call the Customer Service phone number on your Member ID card.

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

*The Medco Pharmacy is part of the Express Scripts family of pharmacies.*

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

N00SCS3A

**MEDCO HEALTH SOLUTIONS, INC.**  
**PO BOX 747000**  
**CINCINNATI OH 45274-7000**



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