NEW PRESCRIPTIONS – Mail your new prescriptions with this form. Number of **NEW** prescriptions enclosed ____

REFILLS – Indicate the prescriptions to be refilled in **Section 3**. Number of **REFILL** prescriptions requested ____

1 INSURANCE INFORMATION

Identification Number:	**Group #:**	**RxBIN #:**
Cardholder's Employer:		

If your prescriptions will be filed under workers' compensation, please provide your injury date: ___/___/___ (MM / DD / YYYY)

2 PATIENT INFORMATION

◯ Check for Spanish

Patient Name: First Middle Initial Last Suffix (JR, SR)

Date of Birth: ___/___/___ (Month / Day / Year)	◯ **Male** ◯ **Female**	◯ Check here for Easy Open caps

Home Address: Street Address Apt./Suite #

City:	**State:**	**Zip Code:**

Daytime Phone #: ( ) -	**Alternate Phone #:** ( ) -

Cell Phone #: ( ) - ◯ Check to receive text notifications & alerts

Email address: ◯ Check to receive email notifications & alerts

Doctor's Name:	**Doctor's Phone #:** ( ) -

*Please complete the following medical information if you are **a new patient** or **information has changed**:*

Drug Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Latex ◯ NSAIDs
◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Medical Conditions: ◯ None ◯ Acid Reflux ◯ Anxiety ◯ Arthritis ◯ Asthma ◯ Depression
◯ Diabetes ◯ Heart Disease ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraines ◯ Osteoporosis
◯ Prostate ◯ Thyroid ◯ Other: _____

List other medications you take not filled by Prescription Mart (including over the counter supplements):

Prescription Mart may substitute FDA-approved generic medications for brand name medications unless you or your prescriber specify otherwise. If you **DO NOT** want generic medications, you must provide specific instructions (including drug names) below. **Refusal of generics may impact your copay**.

3 PRESCRIPTION REFILL INFORMATION

To request prescription **Refills**, write the **Rx Number** and **medication name** below.

1.	2.
3.	4.
5.	6.
7.	8.

4 PAYMENT INFORMATION AMOUNT AUTHORIZED: $_____

If your copay is $0, you do not need to provide payment information.

◯ Call me for payment information

◯ Check or money order enclosed (Payable to: Prescription Mart). Write your Member ID # on your check.
Prescription Mart may charge up to $25 for returned checks.

◯ Charge credit card on file

◯ Apply credit balance to this order

◯ Please charge the following card:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit card number:

Expiration Date: Billing Zip Code:

Name as it appears on card:

◯ Keep this payment method on file for future orders ◯ Use this payment method one time only

DO NOT SEND CASH.

CREDIT CARD HOLDER SIGNATURE: _____ **DATE:**_____

5 SHIPPING ADDRESS *(if different from Home Address listed in Section 2)*

First Name Middle Initial Last Name

Company Name (if applicable)

Street Address

City	State	Zip Code

◯ Check here if you would like us to use this shipping address for this order only and not future orders.

◯ Check here if you would like us to contact you to schedule expedited shipping at your expense.

If your medication(s) require special handling, a team member will reach out to you to advise when delivery is expected.

6 CERTIFICATION

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policy holder and employer in accordance with the Health Insurance Portability and Acountability Act (HIPAA).

PATIENT SIGNATURE: _____ **DATE:**_____