



**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, plus refills for up to 1 year, if appropriate (not a 30-day supply plus refills). 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 1 800 987-5241. 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 drugs 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 less expensive,** generic drug. This applies only to the prescription drug(s) on this order.

Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent drug for a brand name drug unless you or your physician direct otherwise. **Check the box if you do not wish a less expensive brand or generic drug "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.medco.com** or call Member Services at 1 800 987-5241. TTY/TDD users should call 1 800 759-1089.

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

**MEDCO HEALTH SOLUTIONS OF FORT WORTH  
PO BOX 650322  
DALLAS TX 75265-0322**



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