

1 Customer information: Please verify or provide customer information below.

Subscriber #: _____
Rx Grp #: _____
(located under the logo on your ID card)

Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: _____@_____

New shipping address: _____

Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

(Medco will keep this address on file for all orders from this subscriber until another shipping address is provided by any person in this plan.)

Daytime phone: _____

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 subscriber 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 subscriber 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 Medco Health Solutions, Inc.**, and write your subscriber ID number on the front. You can enroll for e-check payments and price medications by calling **1-800-948-8779**.

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 **X** Cardholder signature

Credit card number _____

I authorize Medco to charge this card for all orders from any person in this plan.

Rush the mailing of this shipment (\$15, 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.

FOLD HERE

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Patient/doctor information continued

First name Last name

Birth date (MM/DD/YYYY) Sex M F Patient's relationship to subscriber 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 subscriber Self Spouse Dependent

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

FOLD HERE

Important reminders and other information

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail-order co-payment, regardless of the days' supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with three refills.

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 pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Customer Care number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1-800-MEDICARE (1-800-633-4227).

Medco 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 future refills of that prescription.

For additional information or help, call the Customer Care number on your ID card. TTY/TDD users should call 1-800-759-1089.

Federal law prohibits the return of dispensed controlled substances.

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Mailing instructions: Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P.O. BOX 747000
CINCINNATI OH 45274-7000

