Prescription Transfer Form

Please print using blue or black ink. ***One form per member.***

If you currently use a mail service or local pharmacy to fill your prescriptions, you can easily transfer them to your pharmacy by completing this form. An order will be placed for all prescriptions marked “Fill”.

PRESCRIPTION BENEFIT CARDHOLDER INFORMATION

Prescription Benefit Plan Name:

_____

Member ID #: _____ Group #: _____ BIN #: _____ PCN: _____ Last Name:_____

First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Email Address: _____

Permanent Address: _____

City: _____ State: _____ ZIP: _____

Delivery Address: _____

City: _____ State: _____ ZIP: _____

(If different than the permanent address) □ For this order only

Primary Phone #: (_____) _____-_____ □ Mobile □ Work □ Home

Secondary Phone #: (_____) _____-_____ □ Mobile □ Work □ Home

MEDICATION ALLERGIES

□ No known allergies □ Aspirin □ Codeine □ Iodine □ Quinolones □ Tetracyclines

□ Amoxil/Ampicillin □ Cephalosporins □ Erythromycin □ Penicillin □ Sulfa Drugs

□ Others: _____

HEALTH CONDITIONS

□ None □ Asthma □ Epilepsy □ High blood pressure □ Osteoporosis □ Others: _____

□ Acid Reflux □ Depression □ Glaucoma □ High cholesterol □ Prostate issues

□ Arthritis □ Diabetes □ Heart problem □ Migraine □ Thyroid – low / high

Over-the-counter/herbal medications taken regularly:

_____

PAYMENT & SHIPPING Do not send cash.

□ **Ship overnight** (Please add $____ to order amount)

□ **Check** (Payable to: _____ Pharmacy)

Total Amount Enclosed: $_____

□ **Charge to my credit card on file**

□ **Charge to a NEW credit card:** □ Mastercard □ VISA □ American Express □ Discover

Name as it Appears on Credit Card:

_____

Standard processing time for orders is 2–3 business days from the date the completed order is received at the pharmacy. Please allow additional time for delivery when placing your order. We will contact you if there will be a delay in processing your order. Once shipped, medications may not be returned for a refund or adjustment.

Billing Address:

_____

Billing ZIP Code: _____

Credit Card #: _____—_____—_____—_____

Expiration Date *(month/year)*: ____/_____

Cardholder Signature: _____

Today's Date *(month/day/year)*: ____/____/____

□ *I authorize* _____ *Pharmacy to maintain this NEW credit card on file and use as payment for future charges.*

Signature: _____

Today's Date *(month/day/year)*: ____/____/____

PRESCRIPTION TRANSFER INFORMATION Last Name: _____

First Name: _____ MI: _____ Gender: ☐ Male ☐ Female

RX#: _____

DRUG NAME/STRENGTH: _____

☐ Fill ☐ Do Not Fill At This Time

Directions For Use:

_____

_____

Prescriber Name: _____

Prescriber Phone#: (_____) _____-_____

Pharmacy Name: _____

Pharmacy Phone #: (_____) _____-_____

RX#: _____

DRUG NAME/STRENGTH: _____

☐ Fill ☐ Do Not Fill At This Time

Directions For Use:

_____

_____ ☐ Prescriber and Pharmacy Information Same As Above

Prescriber Name: _____

Prescriber Phone#: (_____) _____-_____

Pharmacy Name: _____

Pharmacy Phone #: (_____) _____-_____

RX#: _____

DRUG NAME/STRENGTH: _____

☐ Fill ☐ Do Not Fill At This Time

Directions For Use:

_____

_____ ☐ Prescriber and Pharmacy Information Same As Above

Prescriber Name: _____

Prescriber Phone#: (_____) _____-_____

Pharmacy Name: _____

Pharmacy Phone #: (_____) _____-_____

RX#: _____

DRUG NAME/STRENGTH: _____

☐ Fill ☐ Do Not Fill At This Time

Directions For Use:

_____

_____ ☐ Prescriber and Pharmacy Information Same As Above

Prescriber Name: _____

Prescriber Phone#: (_____) _____-_____

Pharmacy Name: _____

Pharmacy Phone #: (_____) _____-_____

RX#: _____

DRUG NAME/STRENGTH: _____

☐ Fill ☐ Do Not Fill At This Time

Directions For Use:

_____

_____ ☐ Prescriber and Pharmacy Information Same As Above

Prescriber Name: _____

Prescriber Phone#: (_____) _____-_____

Pharmacy Name: _____

Pharmacy Phone #: (_____) _____-_____

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. **Brand-name medications may be subject to a higher cost.**

Over the Counter Medications

List over the counter medications that you'd like to add.

Drug Name/ Strength: _____ Dosage: _____ Quantity: _____

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time

Drug Name/ Strength: ____________________________________ Dosage: ________________ Quantity: __________

☐ Fill ☐ Do Not Fill At This Time