



## NEW PRESCRIPTION MAIL-IN ORDER FORM

### 1 Member and physician information — please use black or blue ink. One form per member.

Member ID Number	(Additional coverage, if applicable) Secondary Member ID Number		
Last Name	First Name	MI	
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender O M O F	Email	
Physician Name			Physician Phone Number with Area Code

### 2 Health history

**Medication Allergies:**     Aspirin                       Erythromycin                       Quinolones                       Others: \_\_\_\_\_  
 None known                   Cephalosporins                   NSAIDs                               Sulfa                                  \_\_\_\_\_  
 Amoxil/Ampicillin               Codeine                               Penicillin                           Tetracyclines                      \_\_\_\_\_

**Health Conditions:**     Asthma                               Glaucoma                               High cholesterol                   Others: \_\_\_\_\_  
 None known                       Cancer                                   Heart condition                       Osteoporosis                          \_\_\_\_\_  
 Arthritis                               Diabetes                                   High blood pressure                   Thyroid Disease                      \_\_\_\_\_

**Over-the-counter/herbal medications taken regularly:** \_\_\_\_\_

### 3 Pharmacy processing

**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. **If you require brand-name medications, please list those medications here:** \_\_\_\_\_

**Keep on file.** If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here: \_\_\_\_\_

**Notes to pharmacy:** \_\_\_\_\_

### 4 Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to [www.myuhc.com](http://www.myuhc.com) to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

**Ship overnight.** Add \$12.50 to order amount (subject to change).

**Check enclosed.** All checks must be signed and made payable to: OptumRx.

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

**Charge to my NEW credit card.**

New Credit Card Number:

Expiration Date (Month/Year):

Visa, MasterCard, AMEX and Discover are accepted.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, I authorize OptumRx to maintain my credit card on file as payment method for any future charges. To modify payment selection, contact customer service at any time.

### 5 Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

