Medco Pharmacy®
MAIL-ORDER FORM
(Now a part of the Express Scripts family of pharmacies)

HIGHMARK West Virginia | EXPRESS SCRIPTS®

1 Member information: Please verify or provide Member information below.

Member ID:

Group: ***HMRK001***

Name:

Street Address:

Street Address:

Street Address:

City, ST, ZIP:

Daytime phone:

Evening phone:

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

@ .

☐ New shipping address:

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Evening phone:

FOLD HERE

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 the envelope provided.

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

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at **www.mybenefitshome.com**, or call **1-800-820-9730.**

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

Credit card number

Expiration date
M M Y Y

X
Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ 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.

HG8280B

Mailing instructions are provided on the back of this form.

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

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. 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.)

You authorize release of all information to the plan administrator, underwriter, sponsor, and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of you or your family members.

Express Scripts 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 refills of that prescription.

For additional information or help, visit us at **www.mybenefitshome.com** or call Member Service at 1-800-820-9730. TTY/TDD users should call 1-800-759-1089.

For Refills

To order from our website: **www.mybenefitshome.com**. Have your member ID number and prescription (Rx) number on hand. Your 12-digit prescription or Rx number can be found on your refill slip.

To order by phone: Call **1-800-473-3455** to use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

Federal law prohibits the return of dispensed controlled substances. In addition, pharmacies cannot reuse or re-dispense medications that have been returned.

Highmark Blue Cross Blue Shield West Virginia is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

FOLD HERE

ID No: <<XXXXXXXXXXXX>>

Group No: <<XXX>>

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

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