HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

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

Member ID: _____
Group: _____
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

☐ 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.)

Daytime phone: ☐☐☐☐☐☐☐☐☐☐

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 Express-Scripts.com, or call the Member Services phone number found on your ID card.

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 ($21, 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.

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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.)

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 Express-Scripts.com/TRICARE or call Member Services at 1.877.363.1303. TTY/TDD users should call 1.877.540.6261.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Program: <<XXXXXXXXX>>

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.

EXPRESS SCRIPTS
PO BOX 52150
PHOENIX, AZ 85072-2150

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Privacy Act Statement from the Department of Defense
To activate your account, please complete the fields below. Before doing so, you must read this Privacy Statement from the Department of Defense.

Authority: 5 U.S.C. 301 (Departmental Regulations); 10 U.S.C. §§1095b-1095c, and §1097 (Medical and Dental Care); 45 C.F.R. Part 160 and Subparts A and E of Part 164 (Health Insurance Portability and Accountability Act); DTMA 04 (Medical/Dental Claim History Files); and, E.O. 9397, as amended (SSN).

Purpose: Information is being collected to provide pharmacy services to all TRICARE beneficiaries

Routine Uses: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, this information may specifically be used to verify beneficiary eligibility, to provide contracted pharmacy benefits services, to authenticate and identify DoD affiliated personnel, and to register new DoD civilian and military personnel and their authorized dependents for the purpose of obtaining medical benefits or other benefits for which they are qualified.

Disclosure: Submission of this information is voluntary. However, failure to provide the requested information may result in delayed processing of pharmacy services.