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

**Subscriber #:** \_\_\_\_\_

**Rx Grp #:** \_\_\_\_\_  
(located under the logo on your ID card)

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Daytime phone:

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

\_\_\_\_\_@\_\_\_\_\_

New shipping address:

\_\_\_\_\_  
\_\_\_\_\_

(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.)

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 at **www.oxfordhealth.com**, or call **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

\_\_\_\_\_  
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.

## 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

## 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 copayment, 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 Pharmacy Customer Service 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 medication unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic medication.** 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.oxfordhealth.com** or call the Pharmacy Customer Service number on your ID card. TTY/TDD users should call 1-800-759-1089.

*Federal law prohibits the return of dispensed controlled substances.*

**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



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