



# New home delivery prescription 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 code
Phone number with area code		
Date of birth (mm/dd/yyyy)	Email address	
Physician name		
Physician phone number with area code		

## 2. Health history

<b>Medication allergies:</b>	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Quinolones	<input type="checkbox"/> Others: _____
<input type="checkbox"/> None known	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Amoxil/Ampicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracyclines	_____
<b>Health conditions:</b>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Others: _____
<input type="checkbox"/> None known	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid disease	_____

**Over-the-counter medications, vitamins and herbal supplements taken regularly:**

## 3. Payment and shipping information – do not send cash

Standard delivery is included at no charge. Prescriptions should arrive within 5 business days after the pharmacy receives the complete order. The pharmacy will contact you if there will be an extended delay in delivering your medications.

Visit the website listed on your member ID card to check drug pricing before sending payment. Once shipped, medications may not be returned for a refund or adjustment.

<input type="checkbox"/> <b>Expedite shipping.</b> Add \$20.00 to order amount (subject to change).	New credit card number
<input type="checkbox"/> <b>Check enclosed.</b> All checks must be signed and made payable to: Optum Rx.	<input type="text"/>
<input type="checkbox"/> <b>Charge to my credit card on file.</b>	Expiration Date (Month/Year)
<input type="checkbox"/> <b>Charge to my new credit card.</b>	<input type="text"/> / <input type="text"/>
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 Optum Rx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time.

## 4. Mail this completed order form with your new prescription(s) to Optum Rx, P.O. Box 2975, Mission, KS 66201. Do not staple or tape prescriptions to the order form.

