FUTURE SCRIPTS Secure Mail Service Order Form

Mail this form to:

FUTURESCRIPTS SECURE
PO BOX 2110
PITTSBURGH, PA 15230-2110

Enter ID # below if not shown or if different from above

Prescription Plan Sponsor or Company Name

Your Member Services number is: 1-888-678-7015

Please fold here

Please use **blue or black ink, capital letters,** and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

FOR FASTEST SERVICE, to order refills or check order status, go to the web address on your ID card or call toll-free 1-888-678-7015.

A Shipping Address if not shown or different from above.

Last Name | First Name | MI | Suffix (JR, SR)

Street Name | Apt./Suite #

○ **Use this address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

PENNSYLVANIA LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG FOR A BRAND NAME DRUG UNLESS YOU OR YOUR PHYSICIAN DIRECT OTHERWISE. IF YOU DO NOT WANT A LESS EXPENSIVE GENERIC DRUG "PRODUCT", PLEASE PROVIDE SPECIFIC INSTRUCTIONS, INCLUDING DRUG NAMES, IN THE "SPECIAL INSTRUCTIONS" SECTION OF THIS FORM.

We may package all of these prescriptions together unless you tell us not to.
Please turn over to provide additional information.

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C Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs: ◯ Easy open caps ◯ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ◯ M ◯ F Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Health Information: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid Reflux ◯ Glaucoma ◯ Heart Problem ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate Issues ◯ Thyroid ◯ Other: _____

2nd person with a refill or new prescription. This person needs: ◯ Easy open caps ◯ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ◯ M ◯ F Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Health Information: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid Reflux ◯ Glaucoma ◯ Heart Problem ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate Issues ◯ Thyroid ◯ Other: _____

Please fold here →

Please fold here →

D Special Instructions: _____

E How would you like to pay for this order? Fill in the oval to choose a payment.

◯ **Electronic Check.** Pay from your bank account. First time users register online or call Member Services.

◯ **Bill Me Later®.** Works like a credit card. First time users register online or call Member Services.

◯ **Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)

◯ Fill in this oval to use your card on file.

◯ Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER _____ Exp. Date MMYY

Credit Card Holder Signature/Date

◯ **Check or Money Order.** Amount: $ ____ . __

- Make check or money order out to FutureScripts Secure.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

◯ Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Regular delivery is free and will take 7 to 10 days from the day you send this form.

If you want faster delivery, choose:

◯ **2nd Business Day ($17)**

◯ **Next Business Day ($23)**

Business days are only Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.