

Home Delivery Pharmacy Service™ Order Form

Benefits Provided by KeystoneBlue



An HMO from Keystone Health Plan West

Member Information

Member ID: _____

Group: PD1 KHPW001

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Shipping address if different from your mailing address

Check if Temporary Permanent

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.

Daytime telephone

Evening telephone

Patient Information—complete one line for each new prescription (Do not complete for refills)

Patient name and Medicare B number (if applicable)	Patient's relation to plan member (fill in one)	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
3	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

Order Information

Total number of medications in this order (including all refills and new medications)

Check here to have all orders billed to your credit card.

By doing so, you authorize Medco Health to keep your card number on file and bill all future orders directly to your credit card. To enroll by phone, please call 1 800 948-8779.

Subtotal of this order \$

Optional expedited shipping \$9.00 (subject to change)

Total enclosed \$

(do not send cash)

Paying by Credit Card? Visa MC
 Disc/NOVUS AmEx Diners

Paying by check? Write your Member ID on your check or money order made payable to Medco Health.

(information continued on back side)

CREDIT CARD NUMBER

M Y X _____

EXPIRATION DATE

CARDHOLDER SIGNATURE

MEDCO HEALTH
PO BOX 2201
PITTSBURGH PA 15230-9523



FOLD BACK HERE

FOLD BACK HERE

For Refills

To order on line: www.highmarkbcbs.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 4REFILL** (1 800 473-3455) to use the automated refill system. Have your Member ID number and your refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For New Prescriptions

Fill out one line of the Patient Information Section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number.

For All Home Delivery Orders

Place all prescriptions and refill slips together with this completed order form and your co-payment in the enclosed return envelope. Be sure to fold the form as indicated so the address on the bottom right shows through the window.

If You Need Additional Help

Call Member Services at **1 800 903-6228**. Best times to call are Tuesday through Friday afternoons.

Please take a minute to make sure...

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your Member ID on any check or money order.**
- **The Medco Health address on the front shows through the window of the return envelope.**
- **You have filled out the Health, Allergy, and Medication Questionnaire. This information will help Medco Health better serve your prescription drug needs.**

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered to your area. This option must be chosen when you make the order, and cannot be applied after an order is already processed.

Additional Instructions

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all Home Delivery Pharmacy Service orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If you do, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance is paid.

You can call 1 800 948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Get more information on line

Visit on line at www.highmarkbcbs.com



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Health, Allergy & Medication Questionnaire



Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for pharmacy benefits with Medco Health Home Delivery Pharmacy Service™.
- If you need additional forms, you may call your KeystoneBlue Member Service toll free number or you may print a form on-line at www.highmarkbcbs.com.
- **Return this questionnaire with your prescription or refill order form.**

Section 1: Member Identification and Contact

		Area Code	
Group Number	Member Number <small>(Located on your KeystoneBlue ID card or in your benefits information)</small>	- - - - -	Daytime Telephone Number
Member/Subscriber First Name	M.I.	Last Name	

Street Address/Apt. No.	City	State	Zip

Section 2: Drug Allergy Conditions

For each covered family member, include their name, date of birth and gender.
 For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If your medication is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ● Please use blue or black ink.

	Member	Spouse	Dependent	Dependent	Dependent
First Name: <small>Add last name if different than member</small>					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillin/Cephalosporin Antibiotics (e.g., ampicillin, Keflex®)	○	○	○	○	○
Tetracycline Antibiotics	○	○	○	○	○
Erythromycin, Biaxin,® Zithromax®	○	○	○	○	○
Codeine (e.g., Tylenol #3)	○	○	○	○	○
Non-steroidal anti-inflammatory (NSAID) drugs (e.g., Ibuprofen)	○	○	○	○	○
Aspirin (e.g., Salicylates)	○	○	○	○	○
Sulfa Drugs	○	○	○	○	○
Iodine	○	○	○	○	○
Print other drug allergies not listed above in the space provided, i.e. - Morphine					



Continued on back

Section 3: Medical Conditions

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said **that particular family member** has the condition.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure (hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol (hypercholesterolemia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis or emphysema (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies, runny nose, hay fever (allergic rhinitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood sugar (diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic, stomach, or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric reflux, heartburn, or esophagitis (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High pressure in the eyes (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation in the legs (peripheral vascular disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with blood not clotting properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Print other medical conditions not listed above in the space provided, i.e. - <i>Glaucoma</i>					

Did you complete both sides?

Please return the questionnaire with your prescription or refill order form.

Thank you very much.

HMRKKS RF



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