Medco By Mail Order Form

Benefits Provided by Highmark Blue Cross Blue Shield

HIGHMARK. Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

FOLD BACK HERE

Member Information

Member ID: _____

Group: ***PD1 BCWP001***

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Evening telephone ☐☐☐ ☐☐☐ ☐☐☐☐

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.

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		❑ Self ❑ Spouse ❑ Dependent	❑ M ❑ F	/ /		❑ Yes ❑ No
2		❑ Self ❑ Spouse ❑ Dependent	❑ M ❑ F	/ /		❑ Yes ❑ No
3		❑ Self ❑ Spouse ❑ Dependent	❑ M ❑ F	/ /		❑ Yes ❑ No

Order Information

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

Subtotal of this order $☐☐☐.☐☐

☐☐☐.☐☐

Optional expedited shipping
$9.00 (subject to change)

Total enclosed $☐☐☐.☐☐
(do not send cash)

☐ **Check here to have all orders billed to your credit card.**
By doing so, you authorize Medco 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.

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

(information continued on back side)

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CREDIT CARD NUMBER

M ☐☐ Y ☐☐ X_____

EXPIRATION DATE CARDHOLDER SIGNATURE

MEDCO
PO BOX 2201
PITTSBURGH PA 15230-9523

FOLD BACK HERE

For Refills

To order online: **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 Medco By Mail 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 number on any check or money order.**
- **The Medco address on the front shows through the window of the return envelope.**
- **You have filled out the Health and Medication Questionnaire. This information will help Medco 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 Medco By Mail 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 online

Visit us at **www.highmarkbcbs.com**.

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Health & Medication Questionnaire

medco®

Your answers to the following questions will help us provide your prescription drug 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 By Mail**.
- If you need additional forms, you may call your Highmark Blue Cross Blue Shield 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

Group Number

Member Number
(Located on your Highmark Blue Cross Blue Shield ID card or in your benefit information)

Area Code - - 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.

First Name: Add last name if different than member Date of Birth: Gender:	**Member** MM/DD/YYYY ○ M ○ F	**Spouse** MM/DD/YYYY ○ M ○ F	**Dependent** MM/DD/YYYY ○ M ○ F	**Dependent** MM/DD/YYYY ○ M ○ F	**Dependent** MM/DD/YYYY ○ M ○ F
Penicillin/cephalosporin antibiotics (e.g. ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g. Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (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)	○	○	○	○	○
High blood pressure (hypertension)	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol (hypercholesterolemia)	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema (COPD)	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever (allergic rhinitis)	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs (peripheral vascular disease)	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine Headaches	○	○	○	○	○
Print other medical conditions not listed above in the space provided, i.e. - *glaucoma*					

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

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Did you complete both sides? **Thank you very much.**