

Medco By Mail ORDER FORM



medco®



1 Member information: Please verify or provide member information below.

Member ID: _____

Group: HNRXS _____

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

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 membership until another shipping address is provided by any person in this membership.)

Daytime phone: _____

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 the envelope provided.

First name _____

Last name _____

Birth date (MM/DD/YYYY) _____

Sex M F

Patient's relationship to member
 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 member
 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 member ID number on the front. You can enroll for e-check payments and price medications at www.bsneny.com, or call 1-800-939-3751.

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

Credit card number _____

Expiration date

____/____
M M Y Y

Cardholder signature

I authorize Medco to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment (\$14, 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.

Group Number

Member Number

Section 3 : Medical Conditions

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

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

For more information about Medco, please visit us online at www.medco.com.

Please complete both pages and staple together.

Please return the questionnaire with your Medco Delivery form or refill order form.

Thank you very much.