




How to use your online home delivery service forms:

1. Print the Order Form for the New Prescription and the Health, Allergy & Medication Questionnaire (HAQ).
2. Once the forms are printed, be sure to complete all information areas in full. **Please remember to include the HAQ if this is your first order** or if there has been a change you need to let the pharmacist know about.
3. Cut the Order Form for New Prescriptions along the dotted lines where indicated and place both forms, along with your new or renewal prescription from your doctor into a standard, white, business-size #10 envelope.
4. Write or type the address of your home delivery pharmacy on the front of the envelope and mail to Medco Health Solutions.

Please Note: Your medication will be delivered to you within 6 to 10 days after you mail your order. Therefore, when placing your order, you should have at least a 14-day supply of that medication on hand.

 **ORDER FORM FOR NEW PRESCRIPTIONS**

MEMBER ID NUMBER _____

Use Member's ID _____

*Please note: Member ID may be shorter than the boxes provided.

GROUP NUMBER _____

PAYMENT METHOD Credit Card American Express Discover/Novus MasterCard VISA Diners Club Check Money Order

Bill all future orders to this credit card number? YES NO

ACCOUNT NUMBER _____

EXPIRATION DATE _____

CARDHOLDER'S SIGNATURE _____

You authorize release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, 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.

GROUP Name _____

Member's Name _____

Mailing Address _____

City _____ State _____ Apt. # _____

Telephone # _____ Day _____ Evening _____

Temporary Address

PATIENT INFORMATION		DATE OF BIRTH	SELF	SPOUSE	DEPENDENT	DOCTOR'S NAME	DOCTOR'S PHONE
LAST NAME	FIRST NAME						

Total number of prescriptions enclosed: _____

If paying by check, total payment enclosed _____

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.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart Failure (weak heart)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure (hypertension)	<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 (hypercholesterolemia)	<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 (COPD)	<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 (allergic rhinitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood sugar (diabetes)	<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 (GERD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High pressure in the eyes (glaucoma)	<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 the 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, BPH)	<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 not listed above in the space provided. Example - <i>Glaucoma</i> →					

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 prescription or refill order form.

Thank you very much.