I.D. Number _____ **ANCHOR / BWE**

Group/Employer Name _____

COMPLETE FORM TO ORDER - You only need to complete this section for a covered family member the first time the person orders medication, unless any information changes.

MEMBER

Last Name _____ Generation (Jr., Sr., III)

First Name _____ Middle Initial

Nickname

Birthdate (mo/day/ccyr) _____ Gender

Health Conditions
- ❑ Asthma (493.90)
- ❑ Arthritis (714.0)
- ❑ Diabetes (250.01)
- ❑ Depression (311)
- ❑ Glaucoma (365.9)
- ❑ High Cholesterol (272.0)
- ❑ Hypertension (402.90)
- ❑ Thyroid ❑ High (242.9) ❑ Low (244.9)

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

List Other conditions and allergies: _____

Prescribing Physician

Last name _____ First name _____ Phone ( )

Dependent # 1 ■ Spouse ■ Child

Last Name _____ Generation (Jr., Sr., III)

First Name _____ Middle Initial

Nickname

Birthdate (mo/day/ccyr) _____ Gender

Health Conditions
- ❑ Asthma (493.90)
- ❑ Arthritis (714.0)
- ❑ Diabetes (250.0)
- ❑ Depression (311)
- ❑ Glaucoma (365.9)
- ❑ High Cholesterol (272.0)
- ❑ Hypertension (402.90)
- ❑ Thyroid ❑ High (242.9) ❑ Low (244.9)

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

List Other conditions and allergies: _____

Prescribing Physician

Last name _____ First name _____ Phone ( )

Dependent # 2 ■ Spouse ■ Child

Last Name _____ Generation (Jr., Sr., III)

First Name _____ Middle Initial

Nickname

Birthdate (mo/day/ccyr) _____ Gender

Health Conditions
- ❑ Asthma (493.90)
- ❑ Arthritis (714.0)
- ❑ Diabetes (250.0)
- ❑ Depression (311)
- ❑ Glaucoma (365.9)
- ❑ High Cholesterol (272.0)
- ❑ Hypertension (402.90)
- ❑ Thyroid ❑ High (242.9) ❑ Low (244.9)

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

List Other conditions and allergies: _____

Prescribing Physician

Last name _____ First name _____ Phone ( )

Dependent # 3 ■ Spouse ■ Child

Last Name _____ Generation (Jr., Sr., III)

First Name _____ Middle Initial

Nickname

Birthdate (mo/day/ccyr) _____ Gender

Health Conditions
- ❑ Asthma (493.90)
- ❑ Arthritis (714.0)
- ❑ Diabetes (250.0)
- ❑ Depression (311)
- ❑ Glaucoma (365.9)
- ❑ High Cholesterol (272.0)
- ❑ Hypertension (402.90)
- ❑ Thyroid ❑ High (242.9) ❑ Low (244.9)

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

List Other conditions and allergies: _____

Prescribing Physician

Last name _____ First name _____ Phone ( )

(RETURN THIS PORTION)

DETACH RETURN ENVELOPE ALONG THIS PERFORATION

PLEASE COMPLETE THE OTHER SIDE

PLEASE PRINT

Complete all sections to order your medications

MOISTEN, FOLD OVER AND SEAL

EXPRESS SCRIPTS®

Mail Service Benefits

- Free delivery (standard postage)
- Convenient home delivery in 14 days
- Free Drug Interaction screening
- Pharmacist available 24 hours
- 24-hour touch-tone service available for refills or to check status on refills
- VISA, MC, DISCOVER and AMERICAN EXPRESS

QUESTIONS AND ANSWERS

1. **WHEN DO I USE MAIL SERVICE?**
   Mail service should be used for ordering medications to be taken for more than 30 days.

2. **WHAT CAN I DO TO EXPEDITE PROCESSING OF THE PRESCRIPTION(S)?**
   Is the name and ID # clearly written on the prescription? If not, please print the patient's full name, address, phone number, and ID # on the back of the prescription.
   Is the doctor's signature legible and is the office phone number on the prescription? If not, please circle the doctor's name on the prescription blank or print the name clearly on the back of the prescription, along with a phone number. If doctor's DEA # is available, please include.
   Are the directions and quantities on the prescriptions clear? If the doctor writes "As directed" this could delay your order.
   Does the patient's condition require long-term therapy? If so, ask the doctor to write the prescription for the maximum quantity allowed by the prescription plan. Ask your doctor if generic substitution is allowed as this maximizes savings.
   Have you completely filled out the attached mailing envelope including home or evening phone number, if different from your daytime phone number? This helps us if we need to contact you.

3. **WHY ARE THE PATIENT'S ALLERGIES AND HEALTH CONDITIONS IMPORTANT?**
   Registered pharmacists review the patient's record before filling the prescriptions to identify potential adverse reactions and drug interaction problems.

4. **HOW DO I TRANSFER MY PRESCRIPTIONS TO EXPRESS SCRIPTS?**
   Call your doctor and request a new prescription for the maximum days supply allowed by the prescription plan and mail in this envelope or to the address printed above on this form.

TDD Number: 1-800-972-4348

www.express-scripts.com Customer Service: 1-800-879-9080

PLEASE ALLOW 2 WEEKS FOR DELIVERY

TO ORDER: Enclose your original written prescription(s). If you are already taking a medication, call your doctor and request a new prescription for the maximum days supply allowed by your plan.

SHIP TO: ❑ Check here for a temporary address change
Temporary Address Start Date: _____
Temporary Address End Date: _____
❑ Check here for a permanent address change and enter it below

Name _____

Mailing Address _____ Apt. or Suite _____

City _____ State _____ Zip _____

I prefer large print ❑ **Yes** ❑ **No**
I prefer "easy open" caps ❑ **Yes** ❑ **No**

How to contact you if we have questions

		Day	Night
Home Phone	(_____)_____	❑	❑
Work Phone	(_____)_____	❑	❑
Cell Phone	(_____)_____	❑	❑
Pager	(_____)_____	❑	❑

We will dispense FDA approved generic medications when allowed by your physician, subject to the terms outlined in your plan.
***To avoid delay please enclose check, money order or credit card information if any payment is due.**

METHOD OF PAYMENT (Please do not send cash)
No payment is due for a Workers' Compensation claim.
Payable to Express Scripts

❑ Check # _____ Amount _____

❑ Money Order or Cashier's Check Amount _____

❑ Charge this and all future orders to this credit card
❑ Charge to my credit card
❑ VISA ❑ MasterCard ❑ Discover Card ❑ American Express

Credit Card number _____ Expiration date _____

Signature _____

SPECIAL HANDLING REQUIRED: _____

(RETURN THIS PORTION)
DETACH RETURN ENVELOPE ALONG THIS PERFORATION

STLSA.MSF

MLR745

_____

_____

_____

❑ Please check box for a change of address

BWE
ANCHOR / BWE

Place Stamp Here

EXPRESS SCRIPTS®
MAIL PHARMACY SERVICE
PO BOX 66773
SAINT LOUIS MO 63166-6773