Magellan Rx Pharmacy

Magellan Rx Home Order Form

f	Member and physician i	nformation — p	olease use bl	ack or blue ink. (One form per men	mber.	
	Member ID Number					Gender M F	
	Last Name			First Name		MI	
	Delivery Address					Apt.#	
	City	State		ZIP		Phone Number (list in order of preference)	
	Date of Birth Email				()	M H W	
	Physician Name	Physicia	n Phone Numb	er	()	M H W	
4	2 Health history			()	MHW		
	Medication Allergies: Health Conditions: Amoxil/Ampicillin Erythromycin None Known Aspirin NSAIDs Sulfa Cephalosporins Penicillin Tetracyclines Codeine Quinolones Others: List all prescription, over-the-counter and herbal medications taken regularly: (use additional sheet if necessary)						
E	Refills. To order mail service	refills, enter your p	rescription nur	mber(s) here.			
	1:				4:		
	5:Pharmacy processing	6:		7:	8:		
	Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost. Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here: Notes to Pharmacy:						
4	,						
Payment and shipping information — do not send cash.							
	Standard delivery is included at no charge. Most prescription orders arrive within 7 days from the date your order is received. We will contact you if there is an extended delay in delivering your medications. Please call 800.424.8274 if you have any questions. Once shipped, medications may not be returned for a refund or adjustment. Log on to www.magellanrx.com to download additional order forms. I authorize Magellan Rx to charge the following amount to my credit/debit card without prior notification: up to \$150up to \$250up to \$(Other Amount Greater than \$250) Ship overnight. Additional charges will apply. Please call to verify pricing. Charge to my NEW credit card. Visa, MasterCard, AMEX and Discover are accepted. Keep this card on file. Expiration Date (Month/Year) //						
	Signature:		Date:				
	For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance, and other such expenses related to prescription orders. By supplying my credit card number, I authorize Magellan Rx Management to maintain my credit card on file as payment method for any future charges. To modify payment selection, Customer Service can be contacted at any time.						
	Mail this completed order for PO Box 620968, Orlando, FL 3	rm with your new 32862. DO NOT ST	prescription(s) APLE OR TAPE	to Magellan Rx Pha PRESCRIPTIONS TO	armacy, THE ORDER FORM.		