

ORDER FORM FOR NEW PRESCRIPTIONS

Information

ID Number: _____
First Name: _____ Last Name: _____ MI: _____
Birthday: ____ / ____ / ____ Sex: Male Female
 Please, no childproof caps
Company Name: _____ Group Number: _____

Check here if you want your prescriptions transferred but not filled until notified.

Ship to this Address:

Street Address: _____ Apt. or Suite: _____
City: _____ State: ____ Zip Code: _____ - ____
Home Phone Number: _____
Work Phone Number: _____

Physician Information:

First Name: _____ Last Name: _____ MI: _____
Physician's Phone Number: _____

Check here if you DO NOT wish to use a generic product.

If you check the above box, you may be required to pay a higher copayment or your product choice may not be covered by your prescription plan, depending on your plan design. Please refer to your benefit materials for details.

****Payment must accompany your prescription(s). You may pay by check or credit card.*

- Paid by check
 Please charge my credit card

Credit Card #: _____
Exp Date: _____

Relationship to Participant: Self Spouse Dependent

Drug Allergies:

- | | | |
|---|---|--|
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Propoxyphene |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Meperidine/Demerol | <input type="checkbox"/> Red Dye #3 |
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> NSAID's | <input type="checkbox"/> Salicylates |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Morphine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Peanuts | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Yellow Dye #6 |

Other: _____

Medical Conditions (to monitor drug/disease interactions)

- | | | |
|--|---|---|
| <input type="checkbox"/> None Known | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronn's Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Epilepsy/Sieizures | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> BPH | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Insomnia | |

Other: _____

For Refills: Write the HealthFirst Rx Solutions / Integrated HMO Pharmacy Prescription number below or call 1-800-633-7928, 14 to 21 days before running out of your current prescription.

Rx No. _____	Rx No. _____
Rx No. _____	Rx No. _____
Rx No. _____	Rx No. _____

Would you like a call from a Pharmacist to discuss any questions that you may have? Yes No

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the prescription drug program and authorize the release of all information to plan administrator. I certify that I or my dependents for whom the prescriptions are enclosed do not have primary prescription coverage under another plan. If the prescription coverage is denied, I agree to reimburse HealthFirst Rx Solutions / Integrated HMO Pharmacy for the amount of benefit which is being denied under the prescription plan.

Insured's Signature: _____

Date: _____

Prescriptions Enclosed:

Quantity of New Prescriptions: _____

Quantity of Refill Prescriptions: _____

Total Quantity (New + Refill): _____

Copayment Amount Enclosed: \$ _____

MAIL FORM TO INTEGRATED HMO PHARMACY/P.O. BOX 369/BOYS TOWN, NE 68010 / 800-633-7928 / 800-801-2395 FAX