

**1 Member and physician information — please use black or blue ink. One form per member.**

Member ID Number				Gender <input type="checkbox"/> M <input type="checkbox"/> F					
Last Name			First Name			MI			
Delivery Address						Apt. #			
City		State		ZIP		Phone Number (list in order of preference) <small>(circle one)</small>			
Date of Birth / /		Email				( )		M H W	
Physician Name		Physician Phone Number ( )				( )		M H W	

**2 Health history**

<b>Medication Allergies:</b>			<b>Health Conditions:</b>		
<input type="checkbox"/> Amoxil/Ampicillin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> None Known	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> None Known
<input type="checkbox"/> Aspirin	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Codeine	<input type="checkbox"/> Quinolones	<input type="checkbox"/> Others: _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Others: _____
<b>List all prescription, over-the-counter and herbal medications taken regularly:</b> (use additional sheet if necessary)					

**3 Refills.** To order mail service refills, enter your prescription number(s) here.

1: _____	2: _____	3: _____	4: _____
5: _____	6: _____	7: _____	8: _____

**4 Pharmacy processing**

**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:**

**5 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](http://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 \$150 \_\_\_\_\_ up to \$250 \_\_\_\_\_ up to \$\_\_\_\_\_ (Other Amount Greater than \$250)

<input type="checkbox"/> <b>Ship overnight.</b> Additional charges will apply. Please call to verify pricing.	Credit Card Number
<input type="checkbox"/> <b>Charge to my NEW credit card.</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> <b>Charge to my credit card on file.</b>	Visa, MasterCard, AMEX and Discover are accepted.
<input type="checkbox"/> <b>Check enclosed.</b> All checks must be signed and made payable to: Magellan Rx Management	<input type="checkbox"/> <b>Keep this card on file.</b>
	Expiration Date (Month/Year)
	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**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.

**6 Mail this completed order form with your new prescription(s) to Magellan Rx Pharmacy, PO Box 620968, Orlando, FL 32862. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.**