Magellan Rx Pharmacy

Magellan Rx Home Order Form

1 Member and physician information — please use black or blue ink. One form per member.					
Member ID Number					Gender M F
Last Name			First Name		MI
Delivery Address					Apt. #
City	State ZIP		Phone Number (lis		(list in order of preference)
Date of Birth Email				- ()	M H W
Physician Name	hysician Name Physician Phone		er		M н W
2 Health history	()			,	101 11 00
Medication Allergies: Amoxil/Ampicillin Erythromycin None Known Aspirin NSAIDs Sulfa Cephalosporins Penicillin Tetracyclines Codeine Quinolones Others: List all prescription, over-the-counter and herbal medications ta			Health Conditions: Arthritis Glaucoma None Known Asthma Heart Condition Osteoporosis Cancer High Blood Pressure Thyroid Disease Diabetes High Cholesterol Others: ken regularly: (use additional sheet if pecessary)		
Refills. To order mail service refills, enter your prescription in 1: 2:					
5:			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:					
Payment and shipping information — do not send cash.					
Standard delivery is included at no contact you if there is an extended Once shipped, medications may no additional order forms. I authorizeup to \$150up to \$250 _	l delay in delivering ot be returned for Magellan Rx to cha	g your medica a refund or adj arge the followi	tions. Please call 800.424 justment. Log on to www	4.8274 if you have v.magellanrx.com	e any questions. n to download
apply. Please call to verify pricing. Charge to my NEW credit card. Visa,			edit Card Number sa, MasterCard, AMEX and Discover are accepted.		
Check enclosed. All checks must be signed and made payable to: Magellan Rx Management		_ •	ard on file.	Expiration	n 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 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.					