

NEW PATIENT HOME DELIVERY FORM

Please complete all portions of this form by printing in **ALL CAPITAL LETTERS** using **black ink**.
 If there are more than three (3) family members, write the information on a separate piece of paper.
1. PERSONAL INFORMATION

Cardholder ID Number _____
 (Refer to your Plan card)
 Cardholder First Name _____ M.I. Last Name _____

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)
 Tetracycline (07) Erythromycin (09) Other: _____
 No Known Drug Allergies (00) Birth Date _____ Gender _____
 Provide a street address. Certain medications cannot be delivered to a post office box.

Mailing Address

City

State

Phone # _____

ZIP Code _____

Physician Last Name _____

Your phone number is used to provide information about your order.
 Physician Phone # _____

Family Member 1 First Name _____ M.I. Last Name _____

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)
 Tetracycline (07) Erythromycin (09) Other: _____

No Known Drug Allergies (00)

Physician Last Name _____

Birth Date _____

Physician Phone # _____

Family Member 2 First Name _____ M.I. Last Name _____

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfa (15)
 Tetracycline (07) Erythromycin (09) Other: _____

No Known Drug Allergies (00)

Physician Last Name _____

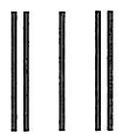
Birth Date _____

Physician Phone # _____

FOLD HERE ←

FOLD HERE ←

Postage Required
 Post Office will not deliver without proper postage



MLRSTLN JAB7667 REV 01/06/2006



EXPRESS SCRIPTS®

**HOME DELIVERY SERVICE
 PO BOX 66773
 SAINT LOUIS MO 63166-6773**



Family Member 3 First Name M.I. Last Name

Drug Allergies: (check all that apply) Penicillin (01) Aspirin (03) Codeine (04) Sulfis (15)
Tetracycline (07) Erythromycin (09) Other:
No Known Drug Allergies (00) Birth Date - - - - - Gender
Physician Last Name Physician Phone # - - - - -

2. PAYMENT INFORMATION

Include payment with your order. **DO NOT SEND CASH.**
Standard delivery of your order is **FREE** and should arrive within 14 days from the date we receive your order.



NOTE: Your check card or credit card will be charged according to your prescription plan. All orders will be charged to this card, unless payment (check or money order) accompanies the order.

Check Card Credit Card
Card # Expiration Date
Cardholder Name

Print name as it appears on card

NOTE: If paying by check or money order, please refer to your prescription plan materials for copay.
Check/Money Order Amount Enclosed \$

3. SIGNATURE REQUIRED

Check any options that apply and sign the following statement.
I prefer non-child resistant (easy open) caps. I request that this and future orders be shipped "signature required" for an additional charge.

I certify that all the information on this form is correct, including any selections made for sending my order "signature required" or for non-child resistant (easy open) caps. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health care operations.

4. REMINDER

Make sure the following information is clear and easy to read on your prescription:
Doctor Information: Name, Signature, and DEA Number. If there are multiple doctors, circle your doctor's name.

Patient Information: First and Last Name, Address, Date of Birth, and ID Number.
Prescription Information: Date Written, Drug Name and Strength, Medication Directions, Medication Quantity, and Number of Refills.

- Prescriptions that do not include this information may be returned to you unfilled.
- FDA approved generic medications will be dispensed when allowed by your physician, subject to the terms outlined in your plan.

QUESTIONS ABOUT YOUR PHARMACY BENEFIT?
CALL THE CUSTOMER SERVICE NUMBER THAT WAS PROVIDED TO YOU.