Mail-Order Request Form

Please complete this form and return via mail or fax:

MedOne Pharmacy Services
PO Box 1537 - Dubuque, IA 52004
Phone: 1-877-896-0919
Fax: 563-588-0173

Please fill in the following information from your MedOne or Healthcare ID card. Fields marked with an * indicate a required field. All others are optional. Incomplete forms will delay processing.

Employer or organization providing prescription coverage _____

*Employee Name_____ *Member ID#_____ *Bin#_____ *Group#_____

Ship to:

*Address _____ *City _____ *State _____ *Zip _____

*Phone Number(s) Day _____ Evening _____ Cell _____

Prescriptions enclosed for (Fill out the name and physician information for each person with a prescription. If a patient has prescriptions from more than one physician, please list the name and phone number for each):

#1 *Patient Name _____

*Prescription	Last Filled	Day Supply	*Prescriber Name	*Prescriber Phone
1.				
2.				
3.				
4.				

#2 Patient Name _____

*Prescription	Last Filled	Day Supply	*Prescriber Name	*Prescriber Phone
1.			1.	
2.			2.	
3.			3.	
4.			4.	

Please list additional medications requested:

_____

If number of prescriptions exceeds 4, please attach an additional sheet

☐ ***Cycle-fill:** By checking this box, you agree to standard automatic medication refill delivery. You will receive your next prescription when 85 – 95% of your medication supply is depleted. This method may only be utilized if you provide your credit card information below.

OR

☐ ***Non cycle-fill:** By checking this box, you agree to the non-standard medication delivery method. You will need to contact the mail order pharmacy to refill your prescriptions and provide the full payment for your prescription prior to MedOne mailing them to your location of choice. Please provide 10-14 days for delivery of medication from time requested.

All prescriptions are filled with safety caps. To request easy open caps, please call 877-896-0919 for an authorization form.

****Payment must be made in full before medications are sent. The payment method provided will be used for all members listed on the form unless otherwise requested. Method of payment (please check one of the boxes below):***

☐ Check or Money Order
☐ Mastercard
☐ VISA
☐ Discover
☐ American Express

_____ Credit Card Number _____ Exp Date _____ CVC code

_____ (*Printed name of insured family member) _____ (*Signature of insured family member) _____ (*Date)

_____ (Printed name of insured family member) _____ (Signature of insured family member) _____ (Date)

I allow MedOne Pharmacy Services to bill my credit-debit card for this and all future orders. I understand my credit-debit card will be billed the following amounts at the time the order is filled: ***Applicable co-payments; co-insurance; deductibles; payments for medications not covered; and any special shipping costs.*** *Receipt of Privacy Practices - by signing above, I acknowledge receipt of the MedOne Healthcare Systems Notice of Privacy Practices and acknowledge the information submitted on this form is accurate and true.*

Please complete the back of this form. ***Incomplete forms may delay processing. Print additional forms at www.medonehs.com***

Please complete the following health, allergy and medication questionnaire for each family member using the mail-order pharmacy service. Include his or her name, date of birth, and gender. For each family member, please check the box indicating an allergy or bad reaction that has occurred at anytime in the past. If a family member is allergic to a medication not listed, please print the name of the medication in the section provided. Also, complete the section regarding health conditions as diagnosed by a physician for each family member.

#1 Patient Information:

*Name _____

*Date of Birth _____ *Gender _____

Current medications, OTC products and supplements currently taking _____

	*Allergies	Reaction
☐	Penicillins/cephalosporins	
☐	Tetracyclin antibiotics	
☐	Erythromycin, Biaxin, Zithromax	
☐	Codeine	
☐	Non-Steroidal anti-inflammatory drug (NSAIDS)	
☐	Sulfa/sulfonamide medications	
☐	Iodine	
☐	Other medication allergies, please list	

	Medical Conditions
☐	Congestive heart failure
☐	High blood pressure
☐	Heart attack or angina
☐	High cholesterol
☐	Stroke
☐	Chronic bronchitis/emphysema (COPD)
☐	Asthma
☐	Allergies, hay fever
☐	Diabetes
☐	Thyroid disease
☐	Peptic, stomach or duodenal ulcer
☐	Gastric reflux, heartburn (GERD)
☐	Inflammatory bowel disease
☐	Glaucoma
☐	Seizures
☐	Poor circulation
☐	Blood clotting disorders
☐	Enlarged prostate
☐	Arthritis
☐	Osteoporosis
☐	Depression
☐	Migraine headaches

Print additional conditions. Attach additional sheets as needed.

Release for Medical Information

By signing below, I authorize MedOne to speak with the following individuals regarding my medical information (please list):

1. _____

2. _____

_____ _____

(Signature) (Date)

#2 Patient Information:

Name _____

Date of Birth _____ Gender _____

Current medications, OTC products and supplements currently taking _____

	Allergies	Reaction
☐	Penicillins/cephalosporins	
☐	Tetracyclin antibiotics	
☐	Erythromycin, Biaxin, Zithromax	
☐	Codeine	
☐	Non-Steroidal anti-inflammatory drug (NSAIDS)	
☐	Sulfa/sulfonamide medications	
☐	Iodine	
☐	Other medication allergies, please list	

	Medical Conditions
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☐	Diabetes
☐	Thyroid disease
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☐	Inflammatory bowel disease
☐	Glaucoma
☐	Seizures
☐	Poor circulation
☐	Blood clotting disorders
☐	Enlarged prostate
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☐	Osteoporosis
☐	Depression
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_____ _____

(Signature) (Date)