## PRESCRIPTION SECTION

Rx For _____ Date _____

Address _____ Phone _____

Dr _____ Dr _____
Dispense as written Substitution permissible, may substitute

Physician Name (Please print) _____

Refills _____ Times Address _____

DEA# _____ Phone _____

Rx For _____ Date _____

Address _____ Phone _____

Dr _____ Dr _____
Dispense as written Substitution permissible, may substitute

Physician Name (Please print) _____

Refills _____ Times Address _____

DEA# _____ Phone _____



# PrimeMail® Pharmacy Fax Order Form

**Physician:** Fax completed form to PrimeMail Pharmacy at **888.214.1811**. **Patient:** PrimeMail Pharmacy is your mail service pharmacy. Please make every attempt to obtain a new written prescription from your physician and send it with a PrimeMail Pharmacy Order Form and payment to: **PrimeMail Pharmacy, P.O. Box 660319, Dallas, TX 75266-0319**

To facilitate your prescription, follow these steps to obtain your prescription:

- Complete the Member, Patient and Payment Sections below using **black ink** only. A credit card number is required at the time the form is submitted.
- Ask your doctor to fill out the Prescription Section and fax this form to **888.214.1811.** Orders not faxed from a licensed physician's office will not be processed.
- Please allow 10 to 14 days for delivery from the date your physician faxes your prescription in.

**By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management.**

**DO NOT FAX PRESCRIPTIONS FOR CONTROLLED SUBSTANCES.**

## MEMBER SECTION

| Member ID Number | | Member Date of Birth |
|---|---|---|
| Member Name (First, Last) | Daytime Phone | Evening Phone |
| Address | | |
| City | State | Zip |

## PATIENT SECTION

| Patient Name (First, last if different from member) | ❑ Male ❑ Female | Patient Date of Birth |
|---|---|---|
| Patient Email Address | | |

**PATIENT ALLERGIES**

❑ Aspirin ❑ Sulfa
❑ Codeine ❑ Tetracycline
❑ Penicillin ❑ Other Allergy _____

**PATIENT CONDITIONS**

❑ Diabetes ❑ Hypertension
❑ Epilepsy ❑ Ulcer
❑ Glaucoma ❑ Other condition _____
❑ Heart condition

| Physician Name | Physician Phone |
|---|---|

**PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.**

## PAYMENT SECTION

Credit Card Number Expiration Date (MM/YYYY)

❑ American Express ❑ Discover
❑ MasterCard ❑ Visa

Credit Card Holder's Signature