Prescription Order Form

BlueCross BlueShield of Illinois

Mail this form to:
PrimeMail®
PO Box 650041
Dallas, TX 75265-0041

For added service:
Visit **www.bcbsil.com**
or call 800.423.1973
TTY 711

Llame la farmacia de PrimeMail en 800.423.1973 o el registro sobre nuestro sitio del web en www.bcbsil.com

CARDHOLDER INFORMATION

Cardholder's ID

Cardholder's Date of Birth (mm/dd/yyyy) / /

Cardholder's Last Name

Cardholder's First Name

MI

Patient's Last Name (if different than cardholder)

Patient's First Name

MI

Patient's Gender: ◯ Male ◯ Female

Patient's Date of Birth (mm/dd/yyyy) / /

Patient's Phone Number – –

Patient's Permanent Address

City

State

ZIP Code

Patient's Email Address

Contact by: ◯ Email ◯ Phone

DRUG ALLERGIES

◯ None ◯ Codeine ◯ Sulfa
◯ Aspirin ◯ Erythromycin ◯ Penicillin
◯ Other _____

HEALTH CONDITIONS

◯ Arthritis ◯ Diabetes ◯ Glaucoma ◯ High cholesterol
◯ Asthma ◯ Depression ◯ Heart condition ◯ Hypertension
◯ Other _____

PATIENT'S PRESCRIPTIONS

Drug Name	Physician/Prescriber's Name and Phone Number	Do not fill at this time
		◯
		◯
		◯

Total Number of Prescriptions: _____

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

CONTINUED ON BACK

SHIPPING INFORMATION

○ **Regular:** No charge ○ **Second business day:** $15* ○ **Next business day:** $22* ***Additional costs charged to you.**

Shipping time does not include processing time. Shipping prices are subject to change.

We are unable to ship second business day or next business day orders to PO boxes.

Shipping address must be a physical location.

Alternate Shipping Address (if different than permanent address)

City State ZIP Code Phone Number

○ This is a change of address ○ This is a one time address ○ Seasonal address from _____ to _____

PAYMENT INFORMATION

Payment is due with each order and may be made by credit card, check or money order. Orders received without payment may delay processing. There is a $20 returned check charge.

Check or money order

Please make check or money order payable to Prime Therapeutics and include your member ID on the memo line. Do not send cash.

○ Check ○ Money Order

Credit card information

To authorize payment by credit card, provide the account number, expiration date and signature. We accept Discover, MasterCard, VISA and American Express. This card will be used for this and all future orders unless we are notified otherwise.

Credit Card Number Expiration Date

○ Use credit card on file, with the last 4 digits of:

Signature _____ Date _____

Unless you or your doctor say not to, and when permitted by law, a brand-name drug may be replaced with a generic drug that has the same active ingredient. (If you choose to take a brand-name drug when a generic version is available, you may have to pay the difference in cost.) By returning this form, you agree to share your protected health information (PHI) with Prime Therapeutics LLC (Prime). Prime's treatment of PHI is designed to comply with privacy laws.

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