Medco By Mail
ORDER FORM

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

medco®

1 Member information: Please verify or provide member information below.

Member ID: ______________________

Group: *BMIBCBSMLG*

Name: ______________________

Street Address: ______________________

Street Address: ______________________

Street Address: ______________________

City, ST, ZIP: ______________________

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
______________ @ ______________ . ________

☐ New shipping address:

____

____

____

(Medco will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

3 Complete your order : You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Medco Health Solutions, Inc.,** and write your member ID number on the front. You can enroll for e-check payments and price medications at **www.medco.com**, or call **1 800 948-8779.**

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number

Expiration date
M M Y Y

X ______________________
Cardholder signature

☐ I authorize Medco to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment ($15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

FORM # HH55428M

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name
Last name

Birth date (MM/DD/YYYY)
Sex
☐ M ☐ F
Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name
1st initial
Doctor's phone number

First name
Last name

Birth date (MM/DD/YYYY)
Sex
☐ M ☐ F
Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name
1st initial
Doctor's phone number

FOLD HERE

Important reminders and other information

Please be sure that you have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription. Check that your doctor has prescribed the maximum days' supply allowed by your plan, plus refills for up to 1 year, if appropriate (not a 30-day supply plus refills).

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

Please take a minute to make sure that you have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment. If you elect to have this and all future orders automatically charged to your credit card, bear in mind that the automated payment plan feature will apply to all mail orders.

Automatic generic equivalent substitution of certain brand-name drugs is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

☐ If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want the less expensive**, generic drug. This applies only to the prescription drug(s) on this order.

☐ Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent drug for a brand name drug unless you or your physician direct otherwise. **Check the box if you do not wish a less expensive brand or generic drug "product."**

Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information or help, visit us at **www.medco.com** or call Member Services at 1 800 903-8346. TTY/TDD users should call 1 800 759-1089.

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Do not use staples or paper clips.

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
PO BOX 6575
CINCINNATI OH 45273-7983

medco®

Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help protect you against potentially harmful drug interactions and side effects. We will alert your pharmacist about possible drug allergies and interactions that can be harmful. To best serve you, we need to know if you have any medication allergies or medical conditions. We also need to know what prescription and nonprescription medications you take regularly.

Your privacy is important to us. Medco complies with federal privacy regulations and will protect this information.

Follow the steps listed below.
Step 1: Verify and complete information in SECTION 1.
Step 2: Complete all sections below using blue or black ink. Please print.
Step 3: Return the completed questionnaire in the self-addressed envelope with your mail-order form or refills. If you do not have a preaddressed envelope, please return the questionnaire to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
PO BOX 6575
CINCINNATI OH 45273-7983

SECTION 1: Patient information

Patient name: ____________ Gender: ____________

Month/Year of birth: ____________ Contact phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Patient member number: ____________ Group: ____________
(Located on your member ID card and/or in your benefit information.)

SECTION 2: Your medication allergies

Fill in the oval **completely if you have had an allergy or serious reaction to any of these medications:**

○	Aspirin and salicylates (for example: ZORprin®, Trilisate®)
○	Codeine (for example: Tylenol® #3)
○	Erythromycin, Biaxin®, Zithromax®
○	Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, Advil®, Motrin®)
○	Penicillins/cephalosporins (for example: Amoxil®, amoxicillin, ampicillin, Keflex®, cephalexin)
○	Sulfa drugs (for example: Septra®, Bactrim®, TMP/SMX)
○	Tetracycline antibiotics
If you have an allergy to a medication that is not listed above, print the name of that medication in the space below. Example: morphine	
other:	
other:	

(over, please)

SECTION 3: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to all that apply.

⬭	Allergies, hay fever (allergic rhinitis)	⬭	Heart failure (CHF)
⬭	Arthritis	⬭	Hemophilia and hemophilia-like conditions
⬭	Asthma	⬭	High blood pressure (hypertension)
⬭	Bladder control problem (urinary incontinence)	⬭	High blood sugar (diabetes)
⬭	Brittle bones (osteoporosis)	⬭	High cholesterol (hypercholesterolemia)
⬭	Chest pain (angina)	⬭	Inflammatory bowel disease
⬭	Crohn's disease	⬭	Migraine headache
⬭	Depression	⬭	Overactive thyroid (hyperthyroid)
⬭	Emphysema (COPD, chronic bronchitis)	⬭	Peptic, stomach, or duodenal ulcer
⬭	Enlarged prostate (benign prostatic hyperplasia, BPH)	⬭	Poor circulation in the legs (peripheral vascular disease)
⬭	Gastric reflux, heartburn, or esophagitis (GERD)	⬭	Seizures (epilepsy)
⬭	Glaucoma	⬭	Stroke (TIA)
⬭	Heart attack (myocardial infarction)	⬭	Underactive thyroid (hypothyroid)

If you have a medical condition that is not listed above, print the name of that medical condition in the space below. Example: breast cancer

other:

other:

SECTION 4: Your nonprescription medications

Fill in the oval completely for each nonprescription medication that you are currently taking on a regular basis.

⬭	Advil®/ibuprofen	⬭	Prilosec OTC®/omeprazole
⬭	Aleve®/naproxen	⬭	Sominex®, Nytol®/diphenhydramine
⬭	Bayer®/aspirin	⬭	Tagamet®/cimetidine
⬭	Benadryl®/diphenhydramine	⬭	Tylenol®/acetaminophen
⬭	Orudis KT®/ketoprofen	⬭	Zantac®/ranitidine
⬭	Pepcid AC®/famotidine		

If you take a nonprescription medication that is not listed above, print the name of that medication in the space below.

other:

other:

SECTION 5: Patient prescription medications*

Please list the **prescription medications** you are currently taking in the space below. *Information can be found on the prescription labels. If none, please check here. **[ ] NONE**

Did you complete both sides? **Thank you very much.**