PrescriptionSolutions®

New Prescription Mail-In Form

1 Please use black or blue ink and mail this completed order form with your new prescription(s). DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Primary Member ID Number: Plan Name:		(Additional coverage, if applicable) Secondary Member ID Number: Plan Name:	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number ( )
Date of Birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Email	
Physician's Name		Physician's Phone Number ( )	

2 Health History — please check all that apply.

If you are a new customer or your allergies or health conditions have changed, please indicate all that apply. The information you provide will allow a more complete review of your current medication request.

Medication Allergies:

- ☐ None
- ☐ Amoxicillin/Ampicillin
- ☐ Aspirin
- ☐ Cephalosporins (e.g. Cephalexin)
- ☐ Codeine
- ☐ Erythromycin
- ☐ NSAIDs (e.g. Ibuprofen)
- ☐ Penicillin
- ☐ Quinolones (e.g. Ciprofloxacin)
- ☐ Sulfa Medications
- ☐ Tetracyclines
- ☐ Other (please specify) _____

Health Conditions:

- ☐ None
- ☐ Allergies — Seasonal
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Other (please specify) _____

Please list any over-the-counter or herbal medications you take regularly:

3 Generic Substitution

FDA-approved generic equivalents will be dispensed for brand-name medications whenever possible, unless you or your physician indicate otherwise. If you require brand-name medications, please list those medications in the Notes to Pharmacy section below with a brand-name only notation. Note: brand-name medications may be subject to a higher cost.

Notes to Pharmacy:

4 Payment and Shipping Information — do not send cash.

Standard delivery is at no charge. Most orders arrive about 7 days from the date your completed order is received. If clarification of your order is required, delivery may take longer. If you would like overnight shipping, please indicate below. Please note that expedited shipping only affects shipping time, not the processing time of your order.

- ☐ **Ship overnight.** Add $12.50 to order amount (subject to change).
- ☐ **Check enclosed.** All checks must be signed and made payable to Prescription Solutions.
- ☐ **Charge to my credit card on file.**
- ☐ **Charge to my NEW credit card.**

New Credit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date (Month/Year) ☐☐ / ☐☐☐☐

Signature: Date:

This credit card will be billed for applicable medications, overnight shipping and outstanding balances. I authorize Prescription Solutions to maintain my credit card on file as payment method for any future charges or outstanding balances. To modify payment selection, please contact Customer Service.

Prescription Solutions, P.O. Box 2975, Mission, KS 66201-1375

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