

MedImpact Direct[®]

Medication Order Form

MedImpact Direct Customer Service

Toll-Free Phone # (855) 873-8739

Email: customerservice@medimpactdirect.com

www.medimpactdirect.com

For refills, please call us or log into your account at www.medimpactdirect.com

Member Information – Please use black or blue ink and CAPITAL LETTERS only

Last Name		First Name		MI	Suffix
Member ID			Plan Name		
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Number of New Prescriptions	<input type="text"/>	Group Number	
Mobile Phone (Include area code) <input type="checkbox"/> Set as Preferred Phone			Home Phone (Include area code) <input type="checkbox"/> Set as Preferred Phone		
Shipping Address Line 1 <input type="checkbox"/> Use this address for this order only			Billing Address (If different from Shipping Address) Line 1 <input type="checkbox"/> Check if same		
Shipping Address Line 2			Billing Address Line 2		
City	State	Zip Code	City	State	Zip Code
Email Address (Email used for order status updates)					

Health Information

Allergies	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracyclines
<input type="checkbox"/> None	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Quinolones	<input type="checkbox"/> Other _____
<input type="checkbox"/> Amoxil/Ampicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Sulfa	_____
Health Conditions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> None	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pregnancy	_____

Physician Information

Physician Last Name	Physician First Name
Physician Phone (Include area code)	Physician Fax (Include area code)

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This form may contain confidential individually identifiable health information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other statutes. This transmission, together with any attachments, is intended only for the use of those to whom it is addressed. If you are not the intended recipient, you are hereby notified that any distribution or copying of this transmission is strictly prohibited. If you received this transmission in error, please notify the original sender immediately and delete this message, along with any attachments, from your computer.

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Payment Information – Do not send cash

For fastest service, pay by credit or debit card. We accept VISA, Mastercard or Discover. If you need to pay by check or money order, please call to speak with a representative.

Cardholder Last Name

Cardholder First Name

Charge my payment method on file (Returning Customers)

Charge my NEW credit card: Visa[®] Mastercard[®] Discover[®]

Ship Expedited Delivery

(Add \$20 to my prescription amount)

Credit Card Number

Expiration Date

Security Code

Standard shipping is free. Your order can take up to 10 days for delivery from the date we receive your order. You may choose expedited delivery via USPS Priority Mail for an additional \$20 by checking the box above. Expedited delivery orders can only be sent to a street address, not a P.O. Box. Expedited delivery affects shipping time, which will reduce the shipping time 1–2 days. Processing time may take 3–5 business days from the time **MedImpact Direct** receives your prescription.

I authorize **MedImpact Direct** to charge my credit card for any copayment, coinsurance, deductible, or any other amount owed on my prescriptions, including any applicable expedited delivery charges.

X

Cardholder's Signature

Date

Unless you check this box, we will keep this credit card on file to pay for any future orders or balance due. You can call **MedImpact Direct** to update this information at any time or you can update your payment preferences by logging into your account at www.medimpactdirect.com.

Authorizations

Check here to request Easy Open Caps. Federal law requires that your prescription shall be dispensed in a container with a child-resistant or safety cap unless you request otherwise. If you would like your prescription with an Easy Open Cap, please check the box.

Pharmacy law may permit a pharmacist to substitute a less expensive, FDA-approved, generic equivalent medication for a brand name-medication unless you or your prescriber indicate otherwise.

By returning this form to **MedImpact Direct**, you verify that the information is correct, that the prescriptions enclosed are for eligible participants, and you consent to the release and use of the patient's health information to the patient's health plan(s) and healthcare providers/agents for health benefit management. **MedImpact Direct's** use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources, such as medical providers, shall be in accordance with federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

X

Signature

Date

Mail this completed order form, along with your prescription and payment information, to:

MedImpact Direct, P.O. BOX 51580, Phoenix, AZ 85076-1580

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