P.O. Box 961025, Fort Worth, TX 76161-9863

Mail Service Input Code: ____________

ORDER FORM & PATIENT PROFILE: Fill out all information below for the primary cardholder.

PART 1: MEMBER INFORMATION

Cardholder I.D. Number *(usually found on your health plan benefit card)*

Group I.D. Number

Plan Name

Last Name

First Name

Initial

Date of Birth

Month / Date / Year

Sex ☐ Male ☐ Female

Number of prescriptions enclosed

Fill in all information below for your "Permanent" shipping address.
(Orders will be shipped to this address unless a different address is specified.)

Street Address

Apt.

City

State

Zip

Home Phone Number (Include Area Code)

Area Code

Work Phone Number (Include Area Code)

Area Code

E-Mail Address

If this order is to be sent to a "Temporary" address, fill in the area below.
(If completed, this address will be used on this order, and then placed on your profile as an alternate. It will only be chosen at your request.)

Street Address

Apt.

City

State

Zip

Home Phone Number (Include Area Code)

Area Code

Work Phone Number (Include Area Code)

Area Code

PAYMENT INFORMATION

Payment required prior to shipping.

❑ Check/Money Order ❑ American Express ❑ VISA ❑ MasterCard ❑ Discover Card Total payment enclosed $ ____________

Payable to Precision Rx

Please do not include cash.

Credit Card Number

Exp Date MONTH / YEAR

May we use the specified card for future orders/unpaid balances? ☐ Yes ☐ No

SIGNATURE______________________________ DATE____________

☐ I approve generic substitutions when available and permitted by my physician.

☐ I do not approve of generic substitutions and request brand only on the prescriptions enclosed. I understand that a higher copayment may apply.

By signing below, I certify that the information provided on this form is correct for myself and all members contained on my health plan policy. I understand that generic medications will be dispensed in all cases where medically appropriate and legally permissible, unless I have stated otherwise above. I further understand that my physician may be contacted about a possible cost-saving medication that is on my health plan's formulary when medically appropriate and legally permissible.

After you have read and completed the section above, please sign and date.

SIGNATURE______________________________ DATE____________

PLEASE PLACE COMPLETED APPLICATION, PRESCRIPTION(S) AND PAYMENT INTO POSTAGE–PAID ENVELOPE

If you have any questions, please contact PrecisionRx at 1-800-293-2202

Please continue on other side ➔

PART 2: MEDICATION AND MEDICAL INFORMATION

Fill in the appropriate box(es) below for each member of the family that is covered.

	Member	Spouse	Dependent	Dependent	Dependent
Last Name *(if different from cardholder name)*					
First Name					
Middle Initial					
Date of Birth					
Sex (M-Male, F-Female)					
Allergies to Medications Check (✔) the appropriate box(es) for any allergies to, or symptoms from, the medication indicated in the left column.					
Penicillin *(31)*					
Codeine *(97)*					
Sulfa *(40)*					
Aspirin *(4)*					
Other (Please list all)					
Other (Please list all)					
Medical History Check (✔) the appropriate box(es) for the medical condition(s) that have been diagnosed by a physician.					
Diabetes *(DIA)*					
High Blood Pressure *(HBP)*					
Heart Condition *(HRT)*					
Thyroid *(THY)*					
Glaucoma *(EYEGLA)*					
Ulcers *(GSTULC)*					
Epilepsy *(MNMCVSNO)*					
Osteoporosis *(BNECPR)*					
Depression *(CNSDEP)*					
Arthritis *(ART)*					
Other Conditions (Please list all)					
Other Conditions (Please list all)					

If additional space is needed, please attach a separate sheet indicating patient name, date of birth, sex, and appropriate allergies to medications and medical history.