Form to transfer your refill prescriptions

Member Information

Member ID Number:

Group:

Name:

Street Address:

Street Address:

Street Address:

City, ST, ZIP:

Daytime telephone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Evening telephone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Shipping address if different from your mailing address

Check if ☐ Temporary ☐ Permanent

I understand the information I provide may be released to and used by the plan administrator, sponsor, employer and/or their agents in connection with the benefit plan programs. Information may be used for other reporting and analysis purposes without identification of me or my family members.

Signature X

Information Required for Each Refill Order (be sure to include a refill slip for each refill you order)

Patient's name	Patient's Relation to plan member	Sex	Birth Date	Doctor's name and phone number	Drug name/ Strength	Current Prescription
1	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			
2	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			
3	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			

Payment Information

Please choose a form of payment:

☐ Money Order

☐ Check (Make payable to Medco Health)

☐ MC ☐ VISA® ☐ AMEX ☐ Diner's Club® ☐ Disc/NOVUS®

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Credit Card Number

M ☐☐ Y ☐☐ X

Expiration Date Cardholder's Signature

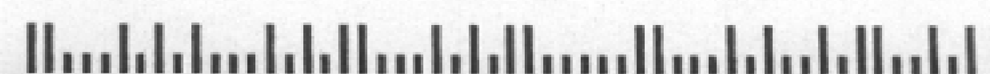
Total Refill Prescriptions Enclosed: ☐

Total Dollar Amount Enclosed: $ ☐

(please do not send cash)

☐ **If you would like us to retain this credit card to conveniently charge all future orders to it, please place a check mark in this box.**

MEDCO HEALTH
P O BOX 650322
DALLAS TX 75265-0322



FORM #TPROF22