



1 Member information: Please provide member information below. (See your ID card.)

Member ID: Prefix: Identification #:

RxGroup: BCWAPDP

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime phone:

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

New shipping address: _____

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

Evening phone:

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)

Gender

M F

Patient's relationship to member

Self Spouse/Domestic partner Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Gender

M F

Patient's relationship to member

Self Spouse/Domestic partner Dependent

Doctor's last name

1st initial

Doctor's phone number

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts**, and write your member ID number on the front. You can enroll for e-check payments and price medications from **MyPharmacyPlus** at premera.com, or call Express Scripts at **1-800-391-9701**.

Number of prescriptions sent with this order:

Payment options: e-check Payment enclosed Credit card

For credit card payments:

Visa MC Discover Amex Diners

Expiration date

M M Y Y

Cardholder signature _____

Credit card number

I authorize Express Scripts to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment (\$21, 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.

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Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Gender

 M F

Patient's relationship to member

 Self Spouse/Domestic partner Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Gender

 M F

Patient's relationship to member

 Self Spouse/Domestic partner Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Your mail-order pharmacy service is provided through Express Scripts, an independent company that offers Premera members speed, convenience and savings for prescription drugs.

Check your prescription. *Your mail service copay applies regardless of the days' supply written. To optimize your benefit, prescriptions should be written for up to the supply maximum allowed by your Plan, plus refills for up to 1 year, if appropriate.* Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

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.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at 1-800-391-9701. To verify Medicare Part B

prescription coverage, call Medicare at 1-800-MEDICARE.

Save money with generic drugs. Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise. *If a brand-name drug is dispensed when a generic is available, you may have to pay the difference in price between the cost of the generic and the cost of the brand-name drug, plus your copay/coinsurance.*

Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.** Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit **MyPharmacyPlus** at *premera.com* or call Member Services at 1-800-391-9701. TTY/TDD users should call 1-800-759-1089.

Federal law prohibits the return of dispensed controlled substances.

Place your prescription(s), this form, and your payment in the envelope (if provided). Be sure the address shows through the window. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000



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