# carelon Rx Mail Service Order Form

**Mail this form to:**

CarelonRx Home Delivery
PO BOX 30980
HONOLULU, HI 96820-9930

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

Please fold here

**Instructions:**

Please use **blue or black ink** and **print in capital letters.** Fill in **both sides** of this form.

**New Prescriptions –** Mail your new prescriptions with this form. Number of **New** prescriptions:

**Refills –** Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

**TO RECEIVE YOUR ORDER SOONER** request refills or new prescriptions online or by phone at the website/phone number on your member ID card.

**A Shipping Address.** To ship to an address different from the one printed above, enter the changes here.

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite #

○ **Use shipping address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

**B Refills.** To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4)

5) 6) 7) 8)

Log in to check order status and access personalized information about your prescription benefits. When getting a new prescription, be sure to ask your doctor to write it for the maximum amount allowed by your plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions. We want to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

Services provided by CarelonRx, Inc.

We may package all of these prescriptions together unless you tell us not to.

**C** **Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

**First person** with a refill or new prescription. ○ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ○ M ○ F Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name _____ Doctor's first name _____ Doctor's phone # _____

Tell us about new health information for 1st person if never provided or if changed.

**Allergies:** ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

**Medical conditions:** ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other: _____

**Second person** with a refill or new prescription. ○ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ○ M ○ F Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name _____ Doctor's first name _____ Doctor's phone # _____

Tell us about new health information for 2nd person if never provided or if changed.

**Allergies:** ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

**Medical conditions:** ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other: _____

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**D** **Special instructions:** _____

**E** **How would you like to pay for this order?** (If your copay is $0, you do not need to provide payment information.)

○ **Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

Please fold here →

Please fold here →

○ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

○ Use your card on file.

○ Use a new card or update your card's expiration date.

CARD NUMBER _____ Exp. Date MMYY

_____
Credit card holder signature/Date

○ **Check or money order.** Amount: $ ____ . ___

- Make check/money order out to CarelonRx Mail
- Write your prescription benefitIDnumberonyour check or money order.
- If your check is returned, we will charge you up to $40.

**Payment for balance due and future orders:** If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

○ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

**Regular delivery is free** and takes up to 5 days after your order is processed.

**If you want faster delivery, choose:**

○ **2nd business day ($17)**

○ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

**Expected processing time from receipt of this form:**

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)