Optum Rx®

NEW PRESCRIPTION MAIL-IN ORDER FORM

1 Member and physician information — please use black or blue ink. One form per member.

Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender ○ M ○ F	Email	
Physician Name		Physician Phone Number with Area Code	

2 Health history

Medication Allergies:	○ Aspirin	○ Erythromycin	○ Quinolones	○ Others:_____
○ None known	○ Cephalosporins	○ NSAIDs	○ Sulfa	_____
○ Amoxil/Ampicillin	○ Codeine	○ Penicillin	○ Tetracyclines	_____
Health Conditions:	○ Asthma	○ Glaucoma	○ High cholesterol	○ Others:_____
○ None known	○ Cancer	○ Heart condition	○ Osteoporosis	_____
○ Arthritis	○ Diabetes	○ High blood pressure	○ Thyroid Disease	_____

Over-the-counter/herbal medications taken regularly:

3 Pharmacy processing

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost. **If you require brand-name medications, please list those medications here:**

Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to pharmacy:

4 Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to **www.optumrx.com** to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

○ **Ship overnight.** Add $12.50 to order amount (subject to change).

○ **Check enclosed.** All checks must be signed and made payable to: OptumRx.

○ **Charge to my credit card on file.**

○ **Charge to my NEW credit card.**

New Credit Card Number

Expiration Date (Month/Year) ___/___

Visa, MasterCard, AMEX and Discover are accepted.

Signature: _____ **Date:** _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time.

5 Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.