guidant rx

Mail Service Pharmacy Prescription Order Form

INSTRUCTIONS

1. Complete all applicable sections on this form. To prevent a delay in processing your order, **please print clearly.**

Use a separate Order Form for each patient.

2. Highlight any changes (i.e. address, telephone, etc.).

3. List health conditions on a separate page.

4. Verify that all applicable sections requiring a signature have been signed.

5. Place this Order Form, any new prescriptions, any additional paperwork and check or money order (if not paying by credit card) into envelope and seal.

6. Address the envelope to:
GuidantRx
2525 Horizon Lake Drive, Ste 101
Memphis, TN 38133
Be sure to include your return address.

7. Attach appropriate postage and mail.

8. Allow ten to fourteen days for your order to arrive at your door.

Most orders are shipped within 24 working hours of receipt.

If your prescription does not have any more refills, you must contact your physician to get a new prescription.

MSP-OF

I. PATIENT INFORMATION: PLEASE COMPLETE A SEPARATE FORM FOR EACH PATIENT

Patient's Name: _____ (First) _____ (M.I.) _____ (Last) Date of Birth: ____ ____ ____ (MM DD YYYY) Gender: ____ (M/F)

Patient's Address: _____ (Street) _____ (Apt Number) (____) ____-____ (Area Code Phone Number)

_____ (City) _____ (State) _____ (Zip Code) E-mail address: _____ @ _____

☐ Check if this is a permanent change of address

Signature: X _____

II. PAYMENT INFORMATION: Please indicate how you will be paying for this order

☐ **Check or money order – amount: $** ☐ **Discover** ☐ **Master Card** ☐ **VISA**

Please complete the following information if you are paying by credit card

Cardholder's Name: _____

Card Number: _____ **Exp. Date:** _____

I authorize GuidantRx to charge to the credit card indicated above all charges pertaining to the new and/or refill prescription requests included with this form. I attest that I am a legal, authorized user of the designated card. I further agree that I will make all necessary payments to my credit card per my cardholder agreement. Charges made to my credit card will appear on my credit card statement as "GuidantRx"

Signature: X _____ **Date:** _____

III. INSURANCE INFORMATION: If your prescription is covered by a pharmacy benefit plan please complete this section.

Member ID No: _____ **Plan Sponsor:** _____ **Group Number:** _____

The above information is found on your ID card

Certification Statement: I certify that the Member Information entered on this form is correct and I am eligible for benefits under the Prescription Drug Program indicated above. I hereby assign to GuidantRx any payments due as a result of this transaction and authorize payment directly to GuidantRx. I also authorize release of all information pertaining to my claim(s) for prescription drugs to GuidantRx and its designees.

Signature: X _____ **Date:** _____

IV. REFILL PRESCRIPTION INFORMATION

List the prescription number(s) and the name of the medication you are ordering in the spaces below. The name of the medication is printed on the label of your prescription container.

Rx#: _____	**Rx Name:** _____	**Contact My MD**	**Yes / No**
Rx#: _____	**Rx Name:** _____	**Contact My MD**	**Yes / No**
Rx#: _____	**Rx Name:** _____	**Contact My MD**	**Yes / No**
Rx#: _____	**Rx Name:** _____	**Contact My MD**	**Yes / No**

V. MEDICAL HISTORY INFORMATION

COMPLETE THIS SECTION WHEN PLACING YOUR FIRST ORDER OR SHOULD YOUR MEDICAL HISTORY CHANGE.

Please list any health conditions, drug allergies, or other medications you are taking in the space below or on a separate page.

Patient Name	Gender	Date of Birth	Drug Allergies:	Current Medications:

VI. PHYSICIAN INFORMATION

Physician's Name: _____ Phone Number: (____) ____-____

Address: _____ City: _____ State: ____ Zip: _____

Mail completed form to: GuidantRx • 2525 Horizon Lake Drive • Ste 101 • Memphis, TN 38133

Or fax to: 1-888-868-2854