OPTUMRx®

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 O M O F	Email	
Physician Name			
Physician Phone Number with Area Code			

2 Health history

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

Over-the-counter/herbal medications taken regularly:

3 Payment and shipping information — do not send cash

Standard delivery is included at no charge. Prescriptions from OptumRx should arrive within 5 business days after we receive the complete order. OptumRx will contact you if there will be an extended delay in delivering your medications.

Visit the URL listed on the back of your member ID card to check drug pricing before sending payment. Once shipped, medications may not be returned for a refund or adjustment.

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

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

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

O **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.

4 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.