



HEALTHTRANS

Mail Service

Toll-free: 1-877-289-0616 | Fax: 1-877-289-0617
HealthTrans | P.O. Box 4057
Greenwood Village | CO 80155-4057

BENEFIT INFORMATION:

HealthTrans must adhere to your benefit plan. If an order cannot be processed due to benefit plan stipulations, HealthTrans will contact you. Call the Member Services phone number provided on the back of your healthcare identification card if you have questions about your drug benefits or copayments. If you have questions about placing your order or your order status, call us toll-free.

I. PATIENT INFORMATION:

Last Name M. Initial First Name

Date of Birth / / Patient Relation to Plan Member Self Spouse Dependent Other: _____ Gender Male Female

II. SHIPPING ADDRESS

Street City

State Zip Home Phone Work Phone

III. HEALTH INFORMATION

Allergies: Yes No If yes, please list : _____

Medical Conditions: Yes No If yes, please list: _____

IV. INSURANCE INFORMATION

Cardholder Last Name (If different from patient) M. Initial First Name

Member ID # Group ID #

Group/Employer Name

V. PAYMENT OPTIONS (PAYMENT MUST ACCOMPANY ORDER)

Credit Card: MasterCard Discover Card Visa Credit Card #:

Name as it appears on card: _____ Exp. Date: _____

BILLING ADDRESS same as shipping address above

Street City

State Zip

The following authorizes HealthTrans to debit the copayment from your checking account. You must include a voided check from this account.

Bank Routing Number: Account Number:

Signature: _____ (Signature authorizes payment via method indicated above)

VI. PRESCRIPTION INFORMATION

Please enclose any new original prescriptions written by your physician and indicate medications below.

Medication Name, Strength, Quantity	Doctor's Name	Doctor's Phone #	Refills (number)

VII. PATIENT AUTHORIZATION

I certify that the information on this form is correct, and authorize release of information regarding my medical and prescription drug history to my program sponsor of the prescription drug program.

Date / /

Signature _____



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INSTRUCTIONS FOR ORDERING YOUR MAINTENANCE/SPECIALTY MEDICATIONS

Welcome to the HealthTrans mail order service plan. The mail order service is designed for those patients who require medications on a recurring basis. Mail order is convenient for you, because the medications will be mailed directly to your home.

Step 1 - Doctor Prescription

To begin using mail order, you must first obtain a written prescription from your doctor for a 90-day supply. Typically, only certain drugs are available for a "maintenance" 90-day prescription. Please have your doctor verify if your particular medication is on the maintenance drug list. The original prescription must be submitted along with the completed mail order form.

Step 2 - Fill Out Form

Take a few minutes to complete the form on the back of this page. Please fill out the order form completely and print clearly. Use one order form for each Patient ordering medication(s). Missing information delays the processing of your order.

Step 3 - Select Payment Option

You may either use a credit/debit card or an electronic check to process your payment. HealthTrans Pharmacy cannot process or ship your order without payment in full. When using a credit card, be sure to include your credit card number and expiration date. When making an electronic transfer from your checking account, you must include a voided check from the account to be debited. HealthTrans Pharmacy provides free standard shipping for prescriptions. If you choose to have your medication shipment rush-ordered, additional costs will apply.

Step 4 - Submit form to HealthTrans

Send a copy of completed form and your original prescription(s) to:

HealthTrans
P.O. Box 4057,
Greenwood Village, CO 80155-4057

MEDICATION SUPPLY CONSIDERATIONS

Be sure to place your order at least 21 days before you run out of your current medication supply. Your benefit plan requires your doctor to write a prescription for a 90-day supply. If you need a prescription fulfilled immediately, ask your doctor to write a 30-day prescription that you can have filled at your local pharmacy, and a 90-day prescription for you to send to HealthTrans Pharmacy. (Please note: If your doctor specifies a quantity less than 90 days, it will be filled as written on the prescription. For example: if the prescription specifies a 30-day supply, HealthTrans Pharmacy will fill the prescription for 30 days.)

Pharmacy Regulations prohibit HealthTrans Pharmacy from honoring requests to cancel or return prescription orders after the order has been received.

HIPAA - This document is covered under the guidelines and federal law regarding patient privacy information.



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Refill Instructions

Toll-free: 1-877-289-0616 | Fax: 1-877-289-0617
HealthTrans | P.O. Box 4057
Greenwood Village | CO 80155-4057

Thank you for ordering your prescription drugs from HealthTrans Pharmacy

To order refills of your medication, please call toll-free, **1-877-839-8121**.
Please have the **Rx Number** from the drug label available (located above your name on the label).

1-800-722-1739

DO NOT TAKE OTHER MEDICATIONS OR ALCOHOL WITHOUT CONSULTING YOUR PHYSICIAN OR PHARMACIST.

1-234-567-8910
DEA2101
THIS FILL: 05/19/05
SAMPLE, DOC

HEALTHTRANS
[YOUR ADDRESS]
ORIGINALLY FILLED: 05/19/05
Rx 1234567
YOUR NAME
CJR

073-000103

HEALTHTRANS

073-000103

PRESCRIPTION USE GUIDELINES

Filed by RX.com, 4710 Mercantile Dr., Ft. Worth, TX 76137

PILL DESCRIPTION
NDC: 00007-0007-07

CAUTION: Federal and/or state law prohibits transfer of this drug to any person other than the patient for whom it was prescribed.

- Please consider HealthTrans Pharmacy for all your maintenance prescriptions.
- Please submit a new form for each new prescription from your doctor.
- Remember to keep your health conditions and allergies up to date and enclose the original prescription.
- Also remember to keep your credit/debit card information current, including your name as it appears on the card and the billing zip code.