Order Form (Please Print)

Additional Prescription Information: Please list any other medications purchased from other pharmacies or over the counter.

Patient Name (First, MI, Last)	Drug Name

Member Name, First, MI, Last			
Address			
City			
State	Zip	DOB	Member ID #
Daytime Number	Evening Number	Group	

Payment Methods	☐ AmEx	☐ One Time Use Only
☐ Check	☐ Master Card	
☐ Money Order	☐ Visa	☐ Approved for Future Orders
☐ Credit Cards	☐ Discover	

Credit Card # Exp. Date

Signature

Make Checks payable to InformedMail. DO NOT Send Cash. Orders received without payment may result in delays in processing, and therefore, extended delivery times.

Shipping Methods

☐ Normal: No Charge ☐ 2nd Day Air: $11.00 ☐ Next Day Air: $25.00

Total Co-Payment:

Shipping:

Total:

State and Federal regulations require patient identification when dispensing controlled substance prescriptions.
Please provide the following information:

Drivers License State: ____ # _____

Social Security # : _____

Please read and sign

I certify the information provided on this form is correct. I authorize the release of all information to the plan sponsor, administrator, or underwriter. I authorize informedMail to substitute generic drugs in all cases when legally permissible with applicable state laws and consistent with doctor's orders. My signature also acknowledges I have been provided with a copy of Notice of Privacy Practice.

Signature Date

Contact Us

Mail (to submit orders)

informedMail
P.O. Box 407096
Ft. Lauderdale, FL 33340-7096

Phone

Customer Care
1-800-881-1966
Available 24 hours a day for your prescription needs.

Online

www.myinformedrx.com

informedRx® an SXC company

Redefining Pharmacy Benefit Management

Home Delivery of Prescription Medications

informedMail™

the convenient and cost effective way to get your prescriptions filled

www.myinformedrx.com

Getting Started

Have your doctor write your prescription for the maximum days supply allowed by your plan (typically a 90-day supply plus 3 refills for a one-year supply).

Write the patient's name, date of birth, and identification number on the back of each original prescription.

Complete the order form included in this brochure. Mail the order form, original prescriptions and payment information to:

informedMail
P.O. Box 407096
Ft. Lauderdale, FL 33340-7096

We'll do the rest!

Most orders are shipped through the US Postal Service with delivery to your home, office or alternate location. Controlled substances may require an adult signature on receipt. Packaging does not show any indication that medications are enclosed.

Please allow 10-14 days for delivery of your prescriptions. Expedited shipping options are also available. Please note that this only reduces transit time and will NOT effect the processing time of your prescription.

informedMail™
an SXC company

www.myinformedrx.com

For added convenience, order refills and print additional forms through our Web site:

www.myinformedrx.com

Frequently Asked Questions About Using Mail Order

What drugs are covered?

Prescription drugs that are covered by your benefit plan are available through mail order. Insulin, insulin syringes, and testing strips need a prescription when you order them through informedMail.

Am I charged for shipping?

Shipping is free. You can get Next Day or Second Day delivery for an extra charge.

When will I get my order?

You should receive your order within 10-14 days. Please allow a few extra days for your first order. If you have questions or do not get your order within 14 days, please contact informedMail at 1-800-881-1966.

Is my information kept private?

Yes, we keep this information completely private. Please read the Notice of Privacy Practices that came with this guide. After reading it, you must sign the bottom of the order form.

Patient Profile Information

	Patient Name (First, MI, Last) / Relation to Member / Gender	Drug Allergies: Other	Penicillin	Codeine	Sulfa	Aspirin	None	Medical Conditions: Other	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Thyroid
1	Patient Name (First, MI, Last)												
	Relation to Member ☐ Dependent ☐ Self ☐ Spouse — Gender ☐ M ☐ F												
2	Patient Name (First, MI, Last)												
	Relation to Member ☐ Dependent ☐ Self ☐ Spouse — Gender ☐ M ☐ F												
3	Patient Name (First, MI, Last)												
	Relation to Member ☐ Dependent ☐ Self ☐ Spouse — Gender ☐ M ☐ F												
4	Patient Name (First, MI, Last)												
	Relation to Member ☐ Dependent ☐ Self ☐ Spouse — Gender ☐ M ☐ F												
	Describe other allergies or conditions												

Detach Here

Patient & Prescription Information: please complete one line for each new prescription.

Note: Please write the member's identification number and patient's date of birth on the back of each prescription.

	Patient Name (First, MI, Last)	Date of Birth	Prescription Name	Doctor Name/ Phone #
1				
2				
3				
4				