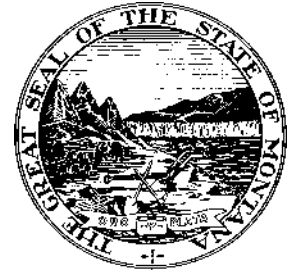




**At Super One Foods**  
 39 Stevi Cutoff Road W.  
 Stevensville, MT 59870  
 1-800-630-3214

# Get Both Mail-Order Savings and In-State Service



## Montana University System

Ridgeway Pharmacy's mail service pharmacy program offers mail service, exceptional customer service, and is based out of the Bitterroot Valley. If you have questions about your mail service pharmacy benefit, please call Ridgeway at 1-800-630-3214.

### Here's how the mail service program benefits you

**QUALITY**- Our mail service is the same as our walk-up service. Every prescription is carefully checked by our pharmacists.

**CONVENIENCE** - With the Ridgeway Pharmacy mail service program, you receive fast, convenient delivery of maintenance medications delivered directly to your home.

**SAVINGS** - You get the savings of mail order but still keep your dollars in state.

*Please see other side for instructions on how to use our mail service.*

### Member Information

Member ID # _____		Company name _____	
Last name _____	First name _____	Middle Initial _____	Sex _____
Mailing address _____		Apt. or Suite _____	
City _____	State _____	Zip _____	
Birthdate (mo/day/yr) _____	Daytime Phone # _____	Evening Phone # _____	

### Check all that apply:

#### Health Conditions

- Asthma (493.90)
- Arthritis (714.00)
- Diabetes (250.01)
- Depression (311.00)
- Glaucoma (365.90)
- High Cholesterol (272.0)
- Hypertension (402.90)
- Thyroid (245.90)
- High (242.9)
- Low (244.9)

#### Drug Allergies

- None
- Aspirin (03)
- Codeine (04)
- Erythromycin (09)
- Iodine (29)
- Penicillin (01)
- Sulfa (15)

#### Other health conditions or drug allergies:

\_\_\_\_\_

\_\_\_\_\_

### Physician Information

Last name _____	First name _____	Phone # _____
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To realize cost savings, we will dispense FDA approved generic medications when allowed by your physician, subject to the terms outlined in your plan design.

### Method of Payment

- Check (Payable to Ridgeway Pharmacy)     VISA     MasterCard

I prefer "easy open" caps     Yes     No

Credit Card Number \_\_\_\_\_    Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

**PLEASE READ AND SIGN:** I certify that the information provided on this form is current and authorize the release of all information to the plan sponsor, administrator or underwriter; and I AUTHORIZE RIDGEWAY PHARMACY TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE, IN ACCORDANCE WITH APPLICABLE LAW, CONSISTENT WITH MY DOCTOR'S ORDERS.

Member's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

**For new mail service prescriptions, please follow these simple steps:**

1. If you need to start your medication right away, have your physician complete two prescriptions. Please be sure the prescription from your physician is legible, includes the drug's name, strength, the quantity to dispense, the exact daily dosage, the physicians' name and phone number.
2. Fill one prescription immediately at a pharmacy and submit the other to the Ridgeway Pharmacy mail service program for a supply determined by your benefit plan. Encourage your physician to write your prescription for the maximum days supply covered by your benefit plan. This will help you maximize your benefit and save money.
3. Complete the mail service participant profile. Please be sure to write your participant ID number in the space provided on the profile. **Your ID number is generally your social security number.** If your benefit plan includes dependent coverage, please fill out the dependent section(s), even if you are not ordering medications for them at this time. If more space is needed for dependents, please list them on a separate sheet.
4. Mail the participant profile, original prescription(s) and copayment (if applicable) to Ridgeway Pharmacy. If your plan requires a percentage copayment, please include your credit card information on the front. You can expect delivery of your order within 14 days from the date your order is postmarked. Refill orders will take 14 days to receive.

**Please note: A complete street address is required for controlled substance medications and an adult signature is required upon receipt.**

**Retain this portion to mail in for first refill, or call 1-800-630-3214 to request refill.**

Name

1 Rx #

Item

2 Rx #

Item

Credit Card Number

Expiration Date

Signature

**Dependent #1**  Spouse  Child

Last Name

First Name

Middle Initial

Birthdate (mo/day/yr)

Sex

**Other health conditions and drug allergies:**

**Physician Information**

Last Name

First Name

Phone #

**Dependent #2**  Spouse  Child

Last Name

First Name

Middle Initial

Birthdate (mo/day/yr)

Sex

**Other health conditions and drug allergies:**

**Physician Information**

Last Name

First Name

Phone #

**Health Conditions**

- Asthma (493.90)
- Arthritis (714.00)
- Diabetes (250.01)
- Depression (311.00)
- Glaucoma (365.90)
- High Cholesterol (272.0)
- Hypertension (402.90)
- Thyroid (245.90)
- High (242.9)
- Low (244.9)

**Drug Allergies**

- None
- Aspirin (03)
- Codeine (04)
- Erythromycin (09)
- Iodine (29)
- Penicillin (01)
- Sulfa (15)

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