Insurance Plan ______________________ Employer Name ______________________

Member Name ______________________ Member Number/Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___

Member Address: Street ______ City ______ State ______ Zip ______

( ) ______________________ Daytime Phone

( ) ______________________ Home Phone

CONFIDENTIAL PATIENT PROFILE

Member ______________________ (Last Name / First / MI) Date of Birth ____/____/____ Sex ______

ALLERGIES **(check boxes)** ☐ None ☐ 1 Penicillin ☐ 2 Chocolate ☐ 3 Sulfa ☐ 4 Aspirin

HEALTH CONDITIONS **(check boxes)** ☐ 5 Thyroid ☐ 6 Diabetes* ☐ 7 Glaucoma ☐ 8 Heart Condition ☐ 9 High Blood Pressure

Other health conditions/allergies ______________________

*Indicate the type of supplies being used - ______________________ Monitor / Lancets / Test Strips

Spouse ______________________ (Last Name / First / MI) Date of Birth ____/____/____ Sex ______

ALLERGIES **(check boxes)** ☐ None ☐ 1 Penicillin ☐ 2 Chocolate ☐ 3 Sulfa ☐ 4 Aspirin

HEALTH CONDITIONS **(check boxes)** ☐ 5 Thyroid ☐ 6 Diabetes* ☐ 7 Glaucoma ☐ 8 Heart Condition ☐ 9 High Blood Pressure

Other health conditions/allergies ______________________

*Indicate the type of supplies being used - ______________________ Monitor / Lancets / Test Strips

Dependent ______________________ (Last Name / First / MI) Date of Birth ____/____/____ Sex ______

ALLERGIES **(check boxes)** ☐ None ☐ 1 Penicillin ☐ 2 Chocolate ☐ 3 Sulfa ☐ 4 Aspirin

HEALTH CONDITIONS **(check boxes)** ☐ 5 Thyroid ☐ 6 Diabetes* ☐ 7 Glaucoma ☐ 8 Heart Condition ☐ 9 High Blood Pressure

Other health conditions/allergies ______________________

*Indicate the type of supplies being used - ______________________ Monitor / Lancets / Test Strips

Dependent ______________________ (Last Name / First / MI) Date of Birth ____/____/____ Sex ______

ALLERGIES **(check boxes)** ☐ None ☐ 1 Penicillin ☐ 2 Chocolate ☐ 3 Sulfa ☐ 4 Aspirin

HEALTH CONDITIONS **(check boxes)** ☐ 5 Thyroid ☐ 6 Diabetes* ☐ 7 Glaucoma ☐ 8 Heart Condition ☐ 9 High Blood Pressure

Other health conditions/allergies ______________________

*Indicate the type of supplies being used - ______________________ Monitor / Lancets / Test Strips

PLEASE READ AND SIGN: I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, administrator or underwriter; and I AUTHORIZE EXPRESS PHARMACY SERVICES 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

PRESCRIPTION ORDER FORM FOR NEW PARTICIPANTS

Prescriptions are for: ☐ Member ☐ Spouse ☐ Dependent

Please write the member number on the back of each prescription.

Childproof caps are used for safety in shipping. **[ ] Check here if you want non-childproof caps with this order.**

Brand-Name Prescriptions

Quantity: __________

Copay: $__________

Total: $__________

Generic Prescriptions

Quantity: __________

Copay: $__________

Total: $__________

Payment is being made by: ☐ Check ☐ Money Order ☐ Credit Card

Please make check or money order payable to: Express Pharmacy Services.

Do not send cash.

If paying by credit card, indicate the credit card you wish to use and provide the account number and the expiration date:

☐ JCPenney ☐ Discover ☐ Master Card ☐ Visa ☐ American Express

Credit Card Account Number: ______________________ Expiration Date: ______________

Signature: ______________________ Date Signed: ______________

☐ Check here if you do not want future orders charged to your credit card on file.

Express Pharmacy Services

Mail Service Prescription Enrollment Order Form

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