

Prescription Order Form



Mail this form to:
PrimeMail®
PO Box 650041
Dallas, TX 75265-0041

For added service: Visit www.bcbsil.com or call 800.423.1973 TTY 711

Llame la farmacia de PrimeMail en 800.423.1973 o el registro sobre nuestro sitio del web en www.bcbsil.com

CARDHOLDER INFORMATION

Cardholder's ID Cardholder's Date of Birth (mm/dd/yyyy)				
Cardholder's Last Name	Cardho	Ider's First Name MI		
Patient's Last Name (if different than ca	rdholder) Patient's First Nam	ent's First Name MI		
Patient's Gender: () Male () Female	Patient's Date of Birth (mm/dd/yyyy) Pat	ient's Phone Number		
Patient's Permanent Address				
City	State ZIP C	ode		
Patient's Email Address		Contact by: () Email () Phone		
DRUG ALLERGIES HEALTH CONDITIONS				
O None O Codeine O Sulfa	Arthritis () Diabetes () Glaud	coma () High cholesterol		
 ○ Aspirin ○ Erythromycin ○ Penic ○ Other	illin () Asthma () Depression () Heart	condition () Hypertension		
PATIENT'S PRESCRIPTIONS				
Drug Name Phys	ician/Prescriber's Name and Phone Number	Do not fill at this time		
		0		
		0		
		0		
Total Number of Prescriptions:				

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

CONTINUED ON BACK

SHIPPING INFORMATION				
Regular: No charge	Second business day	7: \$15*	kt business day: \$22*	*Additional costs charged to you.
Shipping time does not incl	ude processing time. S	Shipping prices a	re subject to change.	
We are unable to ship second	l business day or next bu	usiness day orders	to PO boxes.	
Shipping address must be a p	physical location.			
Alternate Shipping Address (if	f different than permaner	nt address)		
City	State	ZIP Code	Phone Number	
○ This is a change of address	S O This is a one ti	me address	Seasonal address from	m to
PAYMENT INFORMATION				
Payment is due with each orde may delay processing. There			r money order. Orders re	eceived without paymen
Check or money order Please make check or money include your member ID on th			() Check	() Money Order
Credit card information To authorize payment by cred MasterCard, VISA and Americ otherwise.				
Credit Card Number		Expiration Date		
Ouse credit card on file, with	the last 4 digits of:			
Signature			Date	
Unless you or your doctor say	not to, and when permi	tted by law. a bran	d-name drug may be re	placed with a

Unless you or your doctor say not to, and when permitted by law, a brand-name drug may be replaced with a generic drug that has the same active ingredient. (If you choose to take a brand-name drug when a generic version is available, you may have to pay the difference in cost.) By returning this form, you agree to share your protected health information (PHI) with Prime Therapeutics LLC (Prime). Prime's treatment of PHI is designed to comply with privacy laws.

PrimeMail® is a registered trademark of Prime Therapeutics LLC (Prime). PrimeMail is a home-delivery pharmacy service provided by Prime.

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BCBSIL contracts with Prime to provide pharmacy benefit management and pharmacy services. In addition, contracting pharmacies are contracted through Prime. The relationship between Prime and contracting pharmacies is that of independent contractors. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.