Medco By Mail Order Form

Benefits Provided by The Research Foundation of SUNY

THE RESEARCH FOUNDATION
The State University of New York

FOLD BACK HERE

FOLD BACK HERE

For New Prescriptions

Fill out one line of the Patient Information section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number.

For Refills

To order from our website: **www.medco.com**. Have your member ID number and prescription (Rx) number on hand. Your 12-digit prescription or Rx number can be found on your refill slip.

To order by phone: Call **1 800 4REFILL (1 800 473-3455)** to use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For All Mail Orders

Place all prescriptions and refill slips together with this completed order form and your co-payment in an envelope addressed to: **MEDCO PO BOX 650322 Dallas TX 75265-0322**

If You Need Additional Help

Call Member Services at **1 800 711-0917**. The best times to call are Tuesday through Friday afternoons.

See the back of this form for additional instructions.

Member Information

Member ID:
Group: RFOSUNY

Name:_____
Street Address:_____
Street Address:_____
Street Address:_____
City, ST, ZIP:_____

Daytime telephone ☐☐☐ ☐☐☐ ☐☐☐☐
Evening telephone ☐☐☐ ☐☐☐ ☐☐☐☐

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

_____@_____._____

Shipping address if different from your mailing address
Check if ☐Temporary ☐ Permanent

_____
_____
_____

Patient Information–Complete one line for each new patient *(Do not complete for refills)*

	Patient name	Patient's relation to plan member *(fill in one)*	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
2		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
3		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No

Order Information

Total number of medications in this order
(including all refills and new medications) ☐

Subtotal of this order $ ☐☐☐.☐☐

Optional expedited shipping
$9.00 (subject to change) ☐☐.☐☐

Total enclosed
(do not send cash) $ ☐☐☐.☐☐

Paying by credit card? ☐Visa ☐MC ☐Disc/NOVUS ☐AmEx ☐Diners

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
CREDIT CARD NUMBER

M ☐☐ Y ☐☐ EXPIRATION DATE

X _____ CARDHOLDER SIGNATURE

☐ **Check here to have all orders billed to your credit card.**
By doing so, you authorize Medco to keep your card number on file and bill all future orders and any outstanding balances directly to your credit card. To enroll by phone, please call 1 800 948-8779.

Paying by check? Write your member ID number on your check or money order made payable to Medco.

Please be sure to address your envelope to the Medco By Mail facility Printed on this order form.

MEDCO
PO BOX 650322
DALLAS TX 75265-0322

FORM # HB24481M

Please take a minute to make sure...

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your member ID number on any check or money order.**
- **Your envelope is addressed to: MEDCO PO BOX 650322 DALLAS TX 75265-0322**
- **If you have not provided Medco with a Health Allergy & Medications Questionnaire or if you want to provide an update, please include the questionnaire with your order.**

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered in your area. This option must be chosen when you make the order, and it cannot be applied after an order is already processed.

Additional instructions

If you elect to have this and all future orders automatically charged to your credit card (by checking the box on the front or enrolling by phone), bear in mind that the automated payment plan feature will apply to all mail orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If so, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance has been paid.

You can call 1 800 948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Texas law allows a less expensive, generically equivalent drug to be substituted for certain brand-name drugs unless your physician directs otherwise. You have a right to refuse such substitution. Consult your physician or pharmacist concerning the availability of a safe, less expensive drug for your use.

A pharmacist is available during normal business hours to answer questions concerning your prescription.

Get more information from our website

Visit us at **www.medco.com**.

To all Medicare beneficiaries whose private health plan has elected to be billed primary for Medicare Part B coverage:

By choosing the Medco mail-order pharmacy to fill your prescription, you are choosing to use the prescription drug coverage provided by your group health plan. Medco will process your prescription under your group health plan coverage, independent of the Medicare program, and no claim will be submitted to Medicare. If you believe that Medicare may also provide coverage and would like Medicare to pay for your prescription, you should go to a Medicare-participating pharmacy in your area. For a list of convenient Medicare-participating pharmacies, please call your local Medicare carrier or 1 800 MEDICARE. If you have any questions about the difference in coverage between your group health plan coverage and Medicare, please call **1 800 716-2931.**

Health, Allergy & Medication Questionnaire (HMQ)

medco®

Your answers to the following questions will help us provide your prescription drug benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for prescription drug benefits with **Medco By Mail**.
- If you need additional forms you may copy this form or call your toll-free Member Services number.
- **Please remember to print your group and member number on both pages**.
- **Return this questionnaire with your prescription or refill order form**.

Section 1: Member Identification and Contact *(Group and Member number required on all pages)*

Group Number

Member Number *(Located on your pharmacy benefit card and/or in your benefits information)*

Daytime Telephone Number ___ - ___ - ____

Member/Subscriber First name **M.I.** **Last Name**

Street Address/Apt No. **City** **State** **Zip**

Section 2: Drug Allergy Conditions

For each covered family member, include their first name, date of birth and gender.
For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past.
If your allergy is not listed, please print only the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ● ***Please use blue or black ink.***

Please add last name if different than member	**Member**	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name:					
Date of Birth (MM/DD/CCYY):					
Gender:	O **M** O **F**	O **M** O **F**	O **M** O **F**	O **M** O **F**	O **M** O **F**
Penicillin/cephalosporin Antibiotics (e.g. ampicillin, Keflex®)	O	O	O	O	O
Tetracycline antibiotics	O	O	O	O	O
Erythromycin, Biaxin®, Zithromax®	O	O	O	O	O
Codeine (e.g Tylenol #3®)	O	O	O	O	O
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, Advil®, Motrin®)	O	O	O	O	O
Aspirin (e.g. salicylates)	O	O	O	O	O
Sulfa drugs	O	O	O	O	O
Iodine	O	O	O	O	O
If there is a drug allergy to report and not listed above, please print only the name of the drug in the space. Example: *Morphine* →					

Please continue on next page to tell us about any medical conditions.

Group Number

Member Number

Section 3: Medical Conditions

Please list names of each family member enrolled in the appropriate column. Then for each family member, fill in the circle next to each condition if a doctor ever said ***that particular family member*** has any of the following conditions.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart Failure (weak heart)	O	O	O	O	O
High blood pressure (**hypertension**)	O	O	O	O	O
Heart attack or angina	O	O	O	O	O
High cholesterol (**hypercholesterolemia**)	O	O	O	O	O
Stroke	O	O	O	O	O
Chronic bronchitis or emphysema (**COPD**)	O	O	O	O	O
Asthma	O	O	O	O	O
Allergies, runny nose, hay fever (**allergic rhinitis**)	O	O	O	O	O
High blood sugar (**diabetes**)	O	O	O	O	O
Thyroid disease	O	O	O	O	O
Peptic, stomach or duodenal ulcer	O	O	O	O	O
Gastric reflux, heartburn or esophagitis (**GERD**)	O	O	O	O	O
Inflammatory bowel disease (**colitis, Crohn's disease**)	O	O	O	O	O
High pressure in the eyes (**glaucoma**)	O	O	O	O	O
Seizures	O	O	O	O	O
Poor circulation in the legs (peripheral vascular disease)	O	O	O	O	O
Trouble with blood not clotting properly	O	O	O	O	O
Enlarged prostate (benign prostatic hyperplasia, **BPH**)	O	O	O	O	O
Arthritis	O	O	O	O	O
Osteoporosis	O	O	O	O	O
Depression	O	O	O	O	O
Migraine headaches	O	O	O	O	O
Print other medical conditions not listed above in the space provided. Example - *Glaucoma* →					

For more information about Medco, please visit us online at **www.medco.com**.

Please complete both pages and staple together.

Please return the questionnaire with your prescription or refill order form.

Thank you very much.