PrimeMail® New Prescription Order Form

blue of california

Mail this form to:
PrimeMail
P.O. Box 27836
Albuquerque, NM 87125-7836

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CARD HOLDER INFORMATION

Card Holder's ID

Last Name

First Name

MI

Gender: ○ Male ○ Female

Date of Birth (mm/dd/yyyy) __/__/____

Phone Number (___) ___-____

Permanent Address

City

State

ZIP Code ____-____

Email Address

Contact by: ○ Email ○ Phone

Prescriber Last Name

Prescriber Phone Number (___) ___-____

Drug Allergies

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other _____

Health Conditions _____

FAMILY MEMBER #1 INFORMATION

Last Name

First Name

MI

Gender: ○ Male ○ Female

Date of Birth (mm/dd/yyyy) __/__/____

Prescriber Last Name

Prescriber Phone Number (___) ___-____

Drug Allergies

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other _____

Health Conditions _____

FAMILY MEMBER #2 INFORMATION

Last Name

First Name

MI

Gender: ○ Male ○ Female

Date of Birth (mm/dd/yyyy) __/__/____

Prescriber Last Name

Prescriber Phone Number (___) ___-____

Drug Allergies

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other _____

Health Conditions _____

Total Number of New Prescriptions: _____ Mail the original physician-signed prescriptions with this form.

FAMILY MEMBER #3 INFORMATION

Last Name

First Name MI

Gender: ○ Male ○ Female Date of Birth (mm/dd/yyyy) / /

Prescriber Last Name

Drug Allergies

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other

Health Conditions

Prescriber Phone Number ( ) –

SHIPPING INFORMATION

○ **Standard postal:** No charge ○ **Second business day:** $9* ○ **Next business day:** $15*

***Additional costs for expedited shipping.**

Shipping time does not include processing time. We are unable to ship to P.O. boxes for second business day or next business day shipping. Shipping address must be a physical location.

Alternate Shipping Address (if different than permanent address)

City State Zip Code Phone Number ( ) –

○ This is a change of address ○ This is a one time address ○ Seasonal address from _____ to _____

PAYMENT INFORMATION

Payment is due with each order and may be made by credit card, check or money order.
Orders received without payment will delay processing. There is a $20 returned check charge.

Check or money order
Please make check or money order payable to PrimeMail and include your member ID on the memo line. Do not send cash.

○ Check ○ Money Order

Credit card information
To authorize payment by credit card, provide the account number, expiration date and signature. We accept Discover, MasterCard, VISA and American Express. This card will be used for this and all future orders unless we are notified otherwise.

Credit Card Number Expiration Date / ○ Use credit card on file, with the last 4 digits of:

Signature _____ Date _____

Pharmacy law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand name cost.

By returning this form to PrimeMail, you consent to the release and use of the patient's health information to the patient's health plans and health care providers/agents for health benefits management. PrimeMail's use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers; shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

PrimeMail may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product.

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