Christiana Care Mail Order Pharmacy Order Form

Christiana Care Mail Order Pharmacy
200 Hygeia Drive
Newark, DE 19713
Customer Services & Interactive Voice Response: (302) 428-6760
Fax Number: (302) 428-6769

PLEASE COMPLETE ONE FORM FOR EACH PATIENT

PLEASE ALLOW 5 TO 7 BUSINESS DAYS FOR PRESCRIPTION(S) TO ARRIVE IN THE MAIL

☐ **Check here if your personal information has changed**

Patient's Name (Last, First, M) _____

Date of Birth _____

Mailing Address (Street, City, State, Zip) _____

_____

Note: Packages can be shipped to physical addresses only. No PO Boxes.

Express Scripts Member ID#_____ Relation to Member (Self, Spouse, dependent, etc.) _____

Primary Insurance Cardholder_____ _____
(Parent info for minors) Name Contact Phone Number

E-mail Address**:**_____

List any drug allergies:_____

For faster service, visit us online at www.christianacare.org

Prescriptions & Refills

Your health plan requires the use of equivalent generic products **when available**. The brand name medication can be dispensed at the full out-of-pocket cost if you prefer.
☐ I prefer brand name medications only at full out-of-pocket expense for: _____

	New Rx Medication Name Note: A 90-day supply will be provided unless limited by law or Christiana Car Plan Rule	**Rx # if refill**		**Process now or profile the prescription for future use?** (Circle one)
1				Process now profile only
2				Process now profile only
3				Process now profile only
4				Process now profile only
5				Process now profile only

Transfer

☐ **I AM TRANSFERRING PRESCRIPTIONS:**

	Rx # & Medication Name (Note: A 90 day supply will be provided unless limited by law or Christiana Care Plan Rule)	**Drug Store**	**Store Phone#**	**Process now or profile the prescription for future use?** (Circle one)
1				Process now profile only
2				Process now profile only
3				Process now profile only
4				Process now profile only
5				Process now profile only

Payment Information

Payment must be made in advance of shipping. You must specify a payment option and provide complete information for that option with every order submitted.

☐ I am paying by credit card.

_____ _____

Print Cardholder's Name (as it appears on card) Cardholder's Signature

Type of card: ☐VISA ☐Mastercard ☐Flexible Spending

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Credit Card Number Expiration Date

☐ I am paying by payroll deduction.

My Employee Identification Number:

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I HEREBY AUTHORIZE CHRISTIANA CARE HEALTH SYSTEM TO MAKE PAYROLL DEDUCTIONS OF ALL PURCHASES MADE USING MY IDENTIFICATION BADGE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR AND AGREE TO PAY ALL CHARGES MADE AGAINST MY IDENTIFICATION BADGE. I AGREE NOT TO HOLD CHRISTIANA CARE HEALTH SERVICES RESPONSIBLE FOR ANY DEDUCTIONS FROM MY CHECK CAUSED BY CHARGES WHICH I MAY DISPUTE. I FURTHER UNDERSTAND THAT UPON TERMINATION OF MY EMPLOYMENT ANY REMAINING BALANCE WILL BE DEDUCTED FROM ANY ELIGIBLE PAID LEAVE HOURS OR MY FINAL PAYCHECK, IF APPLICABLE. PLEASE SIGN BELOW IF YOU AGREE TO THE TERMS SPECIFIED HERE.

Employee Signature: _____ Date: _____

Revised 02/2011