

## How to get started

Taking advantage of your **mail order benefit** may enable you to receive up to a 90-day supply of your maintenance medication(s). Just ask your physician to write for a 90-day supply, plus additional refills (to be filled at Prescription Mart).

- **Online:** Fill out a your information using our New Patient Enrollment form online.
- **E-prescribe or Fax:** Have your doctor e-prescribe to Prescription Mart or fax your prescription to 1.409.866.1317. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.
- **Mail:** Mail your 90-day prescription and completed Patient Profile and Medication Order Form with payment to PO Box 12607, Beaumont, TX 77726.

## Getting a refill is easy

There are multiple ways to order prescriptions from Prescription Mart Pharmacy.

- **Online:** Log on to [www.prescriptionmartpharmacy.com](http://www.prescriptionmartpharmacy.com) to order refills and download forms.
- **Mail:** Print an order form from our website and mail to PO Box 12607, Beaumont, TX 77726.
- **Phone:** Call us at 800.713.1230 with your prescription number and payment information.

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## Frequently Asked Questions

### When will I receive my medication?

Our biggest mail order partner is USPS, which may take up to 14 days. When shipping specialty medications, we utilize a combo of UPS and FedEx to provide expedited service.

### How much are shipping charges?

In most cases, shipping is free. Should you want your prescription sooner or have special handling needs, there may be a charge.

### What if my medications require special handling?

Don't panic, we're experts. If your medications need refrigeration/special handling, a team member will contact you.

### How will you contact me?

We love to text! We also use email and a standard toll-free telephone number.

### How do I pay for my prescriptions?

Give us a call, we'll handle it. We require payment before we will ship your order (we do not bill). You can pay by personal check, money order, FSA/HRA or major credit card. Please don't send cash.

### How are controlled substances handled?

We do have a serious side, especially when it comes to controlled substances. These prescriptions have strict guidelines and may be handled differently than a noncontrolled medication. Our team will reach out to you to confirm a few additional details.

## CONTACT US

### Toll-free Phone:

800.713.1230

### Fax:

409.866.1317

### Customer Service:

Mon-Fri: 7a-6p CST

Sat: 8a-1p CST

(Closed major holidays)

### Website:

[prescriptionmartpharmacy.com](http://prescriptionmartpharmacy.com)

### Mailing Address:

Prescription Mart

PO Box 12607

Beaumont, TX 77726

NEW PRESCRIPTIONS – Mail your new prescriptions with this form.

Number of NEW prescriptions enclosed \_\_\_\_

REFILLS – Indicate the prescriptions to be refilled in Section 3.

Number of REFILL prescriptions requested \_\_\_\_

**1 INSURANCE INFORMATION**

<b>Identification Number:</b>	<b>Group #:</b>	<b>RxBIN #:</b>
<b>Cardholder's Employer:</b>		
If your prescriptions will be filed under workers' compensation, please provide your injury date: _____ / _____ / _____ <span style="float:right; font-size:small;">MM / DD / YYYY</span>		

**2 PATIENT INFORMATION**  Check for Spanish

<b>Patient Name:</b>			
First	Middle Initial	Last	Suffix (JR, SR)
<b>Date of Birth:</b> _____ / _____ / _____ <span style="font-size:small;">Month / Day / Year</span>	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Check here for Easy Open caps
<b>Home Address:</b>			
Street Address		Apt./Suite #	
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	
<b>Daytime Phone #:</b> ( ) -		<b>Alternate Phone #:</b> ( ) -	
<b>Cell Phone #:</b> ( ) -		<input type="checkbox"/> Check to receive text notifications & alerts	
<b>Email address:</b>		<input type="checkbox"/> Check to receive email notifications & alerts	
<b>Doctor's Name:</b>		<b>Doctor's Phone #:</b> ( ) -	

Please complete the following medical information if you are **a new patient** or **information has changed**:

<b>Drug Allergies:</b> <input type="radio"/> None <input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine <input type="radio"/> Erythromycin <input type="radio"/> Latex <input type="radio"/> NSAIDs <input type="radio"/> Peanuts <input type="radio"/> Penicillin <input type="radio"/> Sulfa <input type="radio"/> Other: _____
<b>Medical Conditions:</b> <input type="radio"/> None <input type="radio"/> Acid Reflux <input type="radio"/> Anxiety <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Depression <input type="radio"/> Diabetes <input type="radio"/> Heart Disease <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Migraines <input type="radio"/> Osteoporosis <input type="radio"/> Prostate <input type="radio"/> Thyroid <input type="radio"/> Other: _____
<b>List other medications you take not filled by Prescription Mart (including over the counter supplements):</b>
Prescription Mart may substitute FDA-approved generic medications for brand name medications unless you or your prescriber specify otherwise. If you <b>DO NOT</b> want generic medications, you must provide specific instructions (including drug names) below. <b>Refusal of generics may impact your copay.</b>

**3 PRESCRIPTION REFILL INFORMATION**

To request prescription Refills, write the Rx Number and medication name below.

1.	2.
3.	4.
5.	6.
7.	8.

**4 PAYMENT INFORMATION** **AMOUNT AUTHORIZED: \$ \_\_\_\_\_**

If your copay is \$0, you do not need to provide payment information.

Call me for payment information

Check or money order enclosed (Payable to: Prescription Mart). Write your Member ID # on your check.  
Prescription Mart may charge up to \$25 for returned checks.

Charge credit card on file

Apply credit balance to this order

Please charge the following card:

Visa  Mastercard  Discover  American Express

Credit card number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Keep this payment method on file for future orders  Use this payment method one time only

**DO NOT SEND CASH.**

**CREDIT CARD HOLDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**5 SHIPPING ADDRESS (if different from Home Address listed in Section 2)**

First Name	Middle Initial	Last Name
Company Name (if applicable)		
Street Address		
City	State	Zip Code
<input type="radio"/> Check here if you would like us to use this shipping address for this order only and not future orders.		
<input type="radio"/> Check here if you would like us to contact you to schedule expedited shipping at your expense.		

If your medication(s) require special handling, a team member will reach out to you to advise when delivery is expected.

**6 CERTIFICATION**

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policy holder and employer in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

**PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**