I Care PHARMACY
"Maine's Mail Order Pharmacy"

You may be eligible to receive up to a 90-day supply of medications.
Please have your doctor write you a prescription today.

Patient Name Last: _____ First: _____ MI: ____

Insurance Company: _____ ID#:_____

Patient Date of Birth Month:_____ Day: _____ Year:_____ Sex: M ☐ F ☐

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Patient Drug Allergies: Example – Penicillin, Codeine, Erythromycin, Etc.

_____

_____

_____

Doctor's Name: _____

Prescription Bottle Caps: Safety ☐ Non-Child Resistant ☐

☐ I Authorize I Care Pharmacy to charge my Credit/Debit card for co-payments each time my prescription(s) are filled.

☐ Mastercard ☐ Visa ☐ Discover

Credit/Debit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date ____/____/____/ CVC/Security Code ___ ___ ___

Cardholder Authorization Signature _____

We welcome your calls. If you have any questions about this program or your medication, our customer service representatives will be happy to assist you.

Phone: 207-472-1302 ♥ 1-888-ICare-19 (1-888-422-7319)
Fax: 207-472-1580 ♥ 1-877-ICare-19 (1-877-422-7319)

Visit our website: www.i-carepharmacy.com