

Directions: Please print in **BLUE** or **BLACK** ink, using all **CAPITAL** letters.



**Member Information**

Male  Female

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

ID Number (located on card) \_\_\_\_\_

Group Number \_\_\_\_\_

**Patient Profile and  
Prescription Order Form**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Physical Address (If different from Mailing Address) \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

**Please Complete**

**ALLERGIES**

- Aspirin
- Cephalosporin
- Codeine derivatives
- Morphine derivatives
- Penicillin
- Sulfa drugs
- None known
- Other (use lines below) \_\_\_\_\_

**HEALTH CONDITIONS**

- Arthritis
- Asthma
- Diabetes
- Glaucoma
- Heart disease
- Hypertension
- Pregnancy
- Thyroid disease
- None known
- Other (use lines at left) \_\_\_\_\_

I would prefer my prescription bottles to have easy open caps  YES  NO

Email-Address (to receive information regarding the processing of your order) \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Preferred Method of Communication (if by phone, specify which number): \_\_\_\_\_

Additional Services Available:  Auto Refill  Text Message (when prescription is complete)  Email Notifications (when prescription is shipped)

**Cell Phone Carrier**

- Verizon  AT&T
- Sprint  T-Mobile
- Other \_\_\_\_\_

For text message notification only

**Dependent Information**

Male  Female

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

Dependent Last Name \_\_\_\_\_

Dependent First Name \_\_\_\_\_

E-mail Address (to receive information regarding the processing of your order) \_\_\_\_\_

Alternate Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Additional Services Available:  Auto Refill  Text Message (when prescription is complete)

Email Notifications (when prescription is shipped)

**Please Complete**

**ALLERGIES**

- Aspirin
- Cephalosporin
- Codeine derivatives
- Morphine derivatives
- Penicillin
- Sulfa drugs
- None known
- Other (use lines below) \_\_\_\_\_

**HEALTH CONDITIONS**

- Arthritis
- Asthma
- Diabetes
- Glaucoma
- Heart disease
- Hypertension
- Pregnancy
- Thyroid disease
- None known
- Other (use lines at left) \_\_\_\_\_

I would prefer my prescription bottles to have easy open caps  YES  NO

**Cell Phone Carrier**

- Verizon  AT&T
- Sprint  T-Mobile
- Other \_\_\_\_\_

For text message notification only

**Member Alternate Shipping Information**

This is alternate shipping information for a member's medication. If a dependent's medication needs to be delivered to a different address, please specify below or contact mRx at 1-866-894-1496.

This shipment only     Temporary address change indicated to the right    Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Alternate Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

**Payment and Shipping Information**

By submitting this form, you hereby authorize release of all information to mRx as required to process your order under your benefit plan. Please enclose your prescription with this form.

Total number of prescriptions this order..... \_\_\_\_\_

- Regular Shipping.....\$ NO CHARGE
- Next Business Day (\$19.00).....\$ \_\_\_\_\_ . \_\_\_\_\_
- 2nd Business Day (\$12.00).....\$ \_\_\_\_\_ . \_\_\_\_\_

Total Shipping Cost.....\$ \_\_\_\_\_ . \_\_\_\_\_

Price of shipping may change by carrier without notification and may vary depending on weight and zone.

**SEND TO:**

**MAIL: mRx, 993 S 24th St., Suite A; Billings, MT 59102;**

**EMAIL (scan form first): mRx@ebms.com or**

**PHONE: 1-866-894-1496**

**FAX: 1-406-869-6552**

**Payment Options (to pay over the phone, call 1-866-894-1496)**

- Check made payable to mRx
- Charge credit card listed below for this order only
- Charge credit card listed below for this and all future orders
- American Express     Visa     Discover     MasterCard

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_ / \_\_\_\_

PLEASE READ AND SIGN: I certify that the information provided on this form is current; and I authorize mRx Pharmacy to substitute generic drugs in all cases when legally permissible, in accordance with applicable law, consistent with my doctors order.

Member/Cardholder Signature \_\_\_\_\_

Date \_\_\_\_\_