HOME DELIVERY ORDER FORM

Express Scripts® Pharmacy

Home Delivery Order Options

Ask your doctor to write your prescription for up to a 90-day supply or the maximum days allowed by your plan with refills up to one year, if appropriate.

ePrescribe: For fastest service ask your doctor to submit prescriptions electronically to Express Scripts® Pharmacy.
Online/mobile app: Log in to **express-scripts.com/rx** or the Express Scripts® mobile app, choose the medicine you want delivered, add it to your cart, then check out.

Fax: Have your doctor call **888.327.9791** for faxing instructions. (Faxes can only be accepted from a doctor's office.)

Phone: Call Express Scripts at **833.750.0201** for assistance in switching to home delivery. TTY/TDD users should call **711**.
Mail: Complete the order form and send to Express Scripts® Pharmacy along with prescriptions and payment.

Please use ALL CAPITAL LETTERS with black or blue ink. Fill in the circles as shown. (●)

1	**Member Information**
Member ID Number	Group #
Member Last Name	Member First Name
Want updates on your order? Register on our website at **express-scripts.com**	Email address
To GO GREEN go to express-scripts.com/green to update your Communication Preferences under Account	

2	**Shipping Address**		
○ Permanent ○ Temporary	If temporary address, please provide effective dates From___/____/____ To ___/___/_____		
Shipping Address Line 1(Street address is preferred over PO Box)			Apt#
Shipping Address Line 2			
City		State	Zip
Primary Phone Number	Choose One M○ H○ W○	Secondary Phone Number	Choose One M○ H○ W○

Shipping Method (Expedited shipping will **not** rush prescription processing)

○ Standard	Free	Arrives within 5-10 days after order is shipped
○ Two Day	$12.00	Arrives 2 business days after order is shipped
○ One Day	$21.00	Arrives 1 business day after order is shipped

3	**Patient Information** Please only include prescriptions for patients covered under the above Member ID
Patient #1	
Patient Last Name	Patient First Name
Patient DOB	Gender ○ Male ○ Female
Physician Name	Physician Phone
Patient #2	
Patient Last Name	Patient First Name
Patient DOB	Gender ○ Male ○ Female
Physician Name	Physician Phone

©2023 Express Scripts® Pharmacy. All Rights Reserved

4 Payment Method — Do not send cash

You authorize us to retain on file your payment card details that you used to make this purchase and to charge your payment card account to pay for any prescription orders requested by you. Should you also choose to enroll in the auto-pay program, you further consent that we may charge your enrolled payment method for prescription orders made by covered household members, including previously ordered prescriptions which are unpaid.

- We will notify you of any changes to this authorization by email or mail as applicable. This Card on File Authorization, and if applicable auto-pay enrollment, will remain in effect until you cancel the authorization by logging into your account or calling **833.750.0201**. TTY/TDD users should call **711.** The transaction amount is determined by your plan's benefit structure at the time the prescription is shipped.
- State law prohibits the return of prescription medications for resale or reuse. We cannot accept the return of properly dispensed prescription medications for credit or refund.
- See our privacy policy for information regarding our use and disclosure of personally identifiable information.

Signature X _____

Credit Card: We accept VISA, MC, Discover, AMEX, Diners	**Check or Checking Account**
◯ **Automatic, ongoing payment through credit card** Authorize to pay for this order and all future orders with the credit card below.	◯ **Automatic, ongoing payment through checking account** I authorize to pay for this order and all future orders with the checking account information below or include a voided check.
◯ **For this order only.** Simply fill in your credit card information below.	◯ **For this order only.** Enclose a check payable to Express Scripts® Pharmacy. Write invoice number on the check.
Credit Card Number _____	**Name of checking account holder** _____
Exp Date _____	**Checking Account Number** _____
	Routing Number (first 9 digits lower-left corner of personal check) _____

Review your account balance and pay outstanding balances anytime at express-scripts.com/rx. To change the limit of the amount we can charge your card without a call to you:

- Go to express-scripts.com/rx
- Log in to your account
- Under Account, select Payment Methods; under the method, select Edit
- Change the payment authorization limit and Save

You can manage all account preferences at express-scripts.com/rx or call Member Services at **833.750.0201**. TTY/TDD users should call **711**.

5 Health History

To update your allergies or health conditions: Visit us at **express-scripts.com/frontend/consumer/#/health-profile** or call **877.438.4417**. This information helps us protect you against potentially harmful drug interactions and allergies.

6 Important reminders and other information

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at **833.750.0201**. TTY/TDD users should call **711**. To verify Medicare Part B prescription coverage, call Medicare at **800.633.4227**.

For additional information or help, visit us at **express-scripts.com/rx** or call Member Services at **833.750.0201**. TTY/TDD users should call **711**.

Your order may be filled at any one of our Express Scripts® pharmacies located nationwide.

7 Generic Substitution

State law permits a pharmacist to substitute a less-expensive generic equivalent drug for a brand-name drug unless you or your physician directs otherwise. Please note that this applies to new prescriptions and to any future refills of that prescription. Also be aware that you may pay more for a brand-name drug.

☐ I do not wish to receive a less expensive brand or generic medication.

If the prescription is being submitted electronically, discuss with your doctor.

Place your prescription(s), order form(s) and your payment in an envelope. Do not use staples or paper clips. Do not affix sticky notes to form.

express-scripts.com/rx

EXPRESS SCRIPTS PHARMACY
PO BOX 66577
ST LOUIS, MO 63166-6577

Notice of availability and nondiscrimination 844-722-4661 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross HMO complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera Blue Cross HMO does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera Blue Cross HMO provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera Blue Cross HMO provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera Blue Cross HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

PREMERA HMO