



Toll Free 1-866-744-0621

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ORDER FORM (Part A)

Please Read

- ◆ Please complete the information on Parts A, B & C of this form (as appropriate). The health history grid (Part C) should be completed for each patient submitting a new prescription for the first time or to make changes for active patients.
- ◆ It is important to include a telephone number in the Member Information area (Part B) in case we have questions about your order.
- ◆ Please complete the payment options section (below). Failure to complete will result in a delay in the processing of your order.
- ◆ Please use a black or blue pen to complete this form. Our mailing address is: **AmeriPharm Pharmacy Services
PO Box 5736
Sioux Falls, SD 57117-5736**

REFILL OPTIONS (OF EXISTING PRESCRIPTIONS ON FILE WITH AMERIPHARM)

1. **FOR FASTER SERVICE, PLEASE VERIFY AVAILABLE REFILLS AND CALL US TOLL FREE AT 1-866-744-0621.**
2. Include your refill slip that accompanied the Patient Advisory Leaflet enclosed with your previous order. Complete payment information and mail to us.
3. Complete REFILL section below including payment information.

Patient _____	Patient _____	Patient _____
Rx # <input type="text"/>	Rx # <input type="text"/>	Rx # <input type="text"/>
Rx # <input type="text"/>	Rx # <input type="text"/>	Rx # <input type="text"/>
Rx # <input type="text"/>	Rx # <input type="text"/>	Rx # <input type="text"/>

TO FILL NEW PRESCRIPTIONS (PLEASE INCLUDE YOUR HARD COPY PRESCRIPTIONS)

Patient Name	Date of Birth	Relationship			(Check One)		Brand Only*	Medication Name	Prescribing Physician Name
		Self	Spouse	Other	Fill Now	Place on File			
							<input type="checkbox"/>		
							<input type="checkbox"/>		
							<input type="checkbox"/>		
							<input type="checkbox"/>		

* I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate, unless the above box is checked. By checking that box, a higher copayment amount may apply.

PAYMENT OPTIONS - Payment to AmeriPharm is due with each order. Do not send cash. Refer to your benefit materials for copayment amount. "Thank you for choosing AmeriPharm".

- Mastercard
 Visa
 American Express
 Discover
 (For fastest service, our preferred payment method)

Account # Exp. Date /

If you use a credit card for your payment, AmeriPharm will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Cardholder's Signature _____ Please keep this credit card on file for future orders.

Check # Money Order #

Check or money order amount \$.

Please write your cardholder ID number on your check or money order. There is a \$30.00 returned check charge.

Delivery: Please allow 14 days from the date you mail your order for delivery of your medicine.