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

Patient Profile and Prescription Order Form

Member Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) ____________

ID Number (located on card) ____________

Group Number ____________

Last Name ____________

First Name ____________

Mailing Address ____________

Physical Address (If different from Mailing Address) ____________

City ____________ State ______ Zip Code ____________

Please Complete

ALLERGIES	HEALTH CONDITIONS
☐ Aspirin	☐ Arthritis
☐ Cephalosporin	☐ Asthma
☐ Codeine derivatives	☐ Diabetes
☐ Morphine derivatives	☐ Glaucoma
☐ Penicillin	☐ Heart disease
☐ Sulfa drugs	☐ Hypertension
☐ None known	☐ Pregnancy
☐ Other (use lines below)	☐ 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 ____________

Cell Phone Carrier

☐ Verizon ☐ AT&T
☐ Sprint ☐ T-Mobile
☐ Other ____________

For text message notification only

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

☐ Email Notifications (when prescription is shipped)

Please Complete

ALLERGIES	HEALTH CONDITIONS
☐ Aspirin	☐ Arthritis
☐ Cephalosporin	☐ Asthma
☐ Codeine derivatives	☐ Diabetes
☐ Morphine derivatives	☐ Glaucoma
☐ Penicillin	☐ Heart disease
☐ Sulfa drugs	☐ Hypertension
☐ None known	☐ Pregnancy
☐ Other (use lines below)	☐ Thyroid disease
____________	☐ None known
____________	☐ Other (use lines at left)

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

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 m*i*Rx 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 m*i*Rx 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: miRx, 993 S 24th St., Suite A; Billings, MT 59102;

EMAIL (scan form first): miRx@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 m*i*Rx

☐ 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 m*i*Rx 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