Blue Cross and Blue Shield of Florida Mail Service Order Form — PrimeMail®

PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescriptions with this completed form to:
  PrimeMail Pharmacy, P.O. Box 660319, Dallas, TX 75266-0319
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **888.214.1811**

For **REFILL** prescriptions you may use:

- **PHONE** — Call our automated refill line at **888.849.7865**
- **WEB** — Visit **www.bcbsfl.com**
- **MAIL** — Mail this form with the refill information completed to:
  PrimeMail Pharmacy, P.O. Box 660319, Dallas, TX 75266-0319

Prescription	Member	Spouse	Dependent	Patient Name	Physician Name/Phone Number/Drug Name (for new prescriptions only)	Prescription Numbers (for refills only)
1	○	○	○			
2	○	○	○			
3	○	○	○			
4	○	○	○			
5	○	○	○			
6	○	○	○			

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

Do not send cash. Orders received without payment will delay processing. Credit card is the only payment option for faxed orders.

○ **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

Check Amount: ____________________ Check Number: ____________________

○ **Payment by credit card** (Provide information below) ○ MasterCard ○ Visa ○ American Express ○ Discover

○ **Use credit card on file, with the last four digits:** ☐☐☐☐

○ **Use alternate credit card number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration Date (MM/YYYY) ☐☐ ☐☐☐☐

○ **Use this card for all future orders**

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

Credit card holder's signature

SHIPMENT SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

○ **Regular** — no charge ○ **Second Business Day** — $9* ○ **Next Business Day** — $15* ***Additional costs charged to you**

If you've chosen Second Business Day or Next Business Day shipping, we are unable to ship to P.O. boxes. Shipping address must be a physical location.

○ **Ship to Permanent Address**

Alternate Shipping Address (If different than permanent address)

City State Zip Code Phone Number ☐☐☐–☐☐☐–☐☐☐☐

Above address is: ○ **For this order only** ○ **For this and all future orders**

All medications in this order will be sent to the address provided on this form. If a family member's medication needs to be delivered to a separate address, please submit a separate order form.

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Blue Cross and Blue Shield of Florida
Mail Order Form — PrimeMail® Pharmacy

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

Questions? Call PrimeMail Pharmacy at 888.849.7865 or visit **www.bcbsfl.com**. ¿ Preguntas? Llame la farmacia de PrimeMail en 888.849.7865 o el registro sobre nuestro sitio del web en **www.bcbsfl.com**.

Member and Dependent History Section information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

If a family member does not want his or her medicine sent in the same package as that of other family members, he or she should complete a separate form.

MEMBER AND DEPENDENT HISTORY SECTION

Member ID Number (on face of member ID card)

Member Last Name Sex: M F

Member First Name MI Birth Date (MM/DD/YYYY)

PCN F L B C

Member Phone Number – –

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other Allergy*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Condition	Hypertension	Ulcer	Other Condition*
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Permanent Address

City State Zip Code

Email Address

* Please detail "other allergy " or "other condition," including related medications. _____

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

Email Address

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

* Please detail "other allergy " or "other condition." _____

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition." _____

ALLERGIES							CONDITIONS							
None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other*	None Known	Diabetes	Epilepsy	Glaucoma	Heart Cond.	Hypertension	Ulcer	Other*
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

- **Do you want the Generic?** ____ **Yes** (if available and your doctor permits) ____ **No**
- Some health plans require the patient to pay the difference between generic and brand name cost. State law allows pharmacist to substitute a less expensive generically equivalent drug for a brand drug unless you or your physician directs otherwise.