

Family Pharmacy

Order Form (Part A)

Please Read

- ◇ Please complete the information on Parts A, B & C of this form (as appropriate). Parts B & C are on the back. 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:

Health First Family Pharmacy
1350 South Hickory Street
Melbourne, FL 32901

Refill Options (Of existing prescriptions on file with Health First Family Pharmacy)

1. **FOR FASTER SERVICE, PLEASE VERIFY AVAILABLE REFILLS AND CALL US TOLL FREE AT 1-866-469-1506.**
2. Include your refill slip that accompanied the Patient Advisory Leaflet enclosed with your previous order.
3. Fill in the patient name(s) and prescription number(s) below, complete the "Payment Options" section and mail or fax to us.

Patient Name: _____

Patient Name: _____

Patient Name: _____

Rx#

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Rx#

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Rx#

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Rx#

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Rx#

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Rx#

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Rx#

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Rx#

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Rx#

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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			

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

Payment Options - Payment to Health First Family Pharmacy is due with each order. Do not send cash. Refer to your benefit materials for co-payment amount(s).

"Thank you for choosing Health First Family Pharmacy!"

Credit Card: MasterCard Visa American Express Discover (For fastest service, our preferred payment method is credit card.)

Name on Credit Card _____

Account # _____ Expiration Date ____ / ____

Please note: If you use a credit card for your payment, Health First Family Pharmacy 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: _____

Delivery: Please allow 10-14 days from the date you mail your order for delivery of your medicine



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Member Information (Part B)

(Please complete with each order using black or blue ink)

Cardholder ID# (See ID Card) _____ RxBIN# (see ID card) _____

Rx Group# (See ID Card, if applicable) _____ PCN (see ID card) _____

Last Name of Cardholder _____ First Name of Cardholder _____

Street/ Delivery Address (Note: Check here ___ if remaining information is same as previous orders and proceed to "Health History" section)

Apt / Unit #	City	State	Zip
_____	_____	_____	_____

Address above is for: (check only if applicable) _____ This order only _____ Permanent address change

Daytime Phone Number _____ Evening Phone Number _____

Health History (Part C)

Please Complete This Health History Grid With Your First Order Or As Information Changes

Please complete information for you and all covered family members. If you are unsure about any health conditions, check with your Doctor. This portion will not be required on subsequent orders unless there have been changes in health or coverage status.

<input type="checkbox"/> Check if information has changed		Birth Date (MM/DD/YY)	M / F	No Known Allergy	Aspirin Allergy	Penicillin Allergy	Sulfa Allergy	Other Allergy*	Diabetes	Epilepsy	Glaucoma	Heart Condition	High Blood Pressure	Thyroid	Ulcer	Other Condition*
	Name (First, Middle initial, Last)															
Member																
Spouse																
Dependent																
Dependent																
Dependent																
Dependent																
Dependent																

If you have additional dependents or require more space, please attach a separate note.

*Please indicate "Other Allergy"

*Please indicate "Other Conditions"

Over the counter medications / patient name

I represent that the information on this form is correct, and authorize the release of information regarding medical and prescription drug history and treatment to Health First Family Pharmacy.

I have read and accepted the Health First Joint Notice of Privacy Practices
(located at http://www.healthfirsthealthplans.org/patients_visitors/nopp.pdf)

Signature _____ Date _____