Amerihealth Insurance Company of New Jersey
QCC Insurance Company d/b/a Amerihealth Insurance Company
Amerihealth HMO, Inc.

For information, call
1-888-678-7012 or log on to
www.amerihealthexpress.com.

Mail Service Order Form

Instructions: Please PRINT in CAPITAL letters using BLACK ink only. Fill in the applicable ovals completely(●). Mail this completed form, the doctor's signed prescription(s), and your payment to Caremark in the envelope provided or to the address on the bottom of this form.

1 Member Information/ Health History

Primary Member Identification Number *(refer to your prescription card)*

Date Form Submitted: ☐☐ – ☐☐ – ☐☐☐☐

Primary Member Name *(Last Name)* *(First Name)* *(MI)*

Delivery Address *(if you select 2nd Day or Next Day shipping, fill in a street address, not a P.O. Box)*

City **State** **Zip**

Phone Number

(☐☐☐) ☐☐☐ – ☐☐☐☐

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

E-mail Address, if available

This information will not be shared with any outside party. If other household members also use this e-mail address, they may be able to access your health information.

Mark all allergies or conditions that apply to you, your spouse or covered dependents that have a prescription submitted with this form by completely filling in the oval below that description. Contact your doctor if you are unsure about any health conditions. This information will not be required on future order forms unless there has been a change in health status.

	Birthdate																
	M M	D D	Y Y Y Y	Male/Female (M / F)	**No Known Allergies**	Penicillin Allergy	Sulfa Allergy	Other Allergies (list below)	Diabetes	Thyroid	Heart Condition	High Blood Pressure	Ulcers	Epilepsy	Glaucoma	Other Conditions *(list below)*
Primary Member's First Name	☐☐	☐☐	☐☐☐☐	☐	○	○	○	○	○	○	○	○	○	○	○	○	○
Spouse's First Name	☐☐	☐☐	☐☐☐☐	☐	○	○	○	○	○	○	○	○	○	○	○	○	○
Other Dependent's First Name	☐☐	☐☐	☐☐☐☐	☐	○	○	○	○	○	○	○	○	○	○	○	○	○
Other Dependent's First Name	☐☐	☐☐	☐☐☐☐	☐	○	○	○	○	○	○	○	○	○	○	○	○	○

Please write first name and then list "other allergies" and/or "other conditions" referenced above _____

_____

List any non-prescription medications that you take on a regular basis or prescription medications that you obtain without your prescription plan: _____

_____

_____

2 New Prescription Information

Enclose original doctor-signed prescription(s) and payment with this form. Ask your doctor to write your mail order prescription for the maximum supply allowed by your plan (if appropriate).

Prescriptions are for: ○ Primary Member ○ Spouse of Primary Member ○ Other Dependent(s)

Total number of medications in this order:

Doctor Name ***(Last Name)*** ***(First Name)***

Doctor Phone Number

( ) –

○ Mark here if you want your mail service materials printed in Spanish.

Generic Medications: Pharmacies will substitute brand name drugs with the generic version whenever possible. Caremark may contact your doctor regarding generic substitution. You have a right to refuse such substitution. **If you do not want the generic version of your brand name drug, please write this on the comment line below.** Choosing a brand name drug instead of a generic may cost more, depending on your prescription plan.

Comments _____

3 Shipping/ Payment Information

Your order will be shipped standard delivery at no charge. Please allow 14 days from the date you mail your order for delivery of your medicine. If you prefer expedited delivery, mark the appropriate oval. Expedited shipping only affects shipping time, not processing time of your order.

○ **2nd Business Day = $10** (per order)

○ **Next Business Day = $15** (per order)

All medications in this order will be sent in the same package to the address provided. 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 order form.

Payment, when applicable, is due with each order and may be made by credit card, check or money order. Payment by credit card is preferred. If paying by check, make the check payable to Caremark. Please write your member identification number on your check. There is a $20 returned check charge. **Do not send cash.** Orders received without payment may result in a delay of processing. Any outstanding balances will be the responsibility of the primary insured.

If you have questions about your payment amount, call the number on your prescription card or the phone number printed on the front of this form, if available.

○ Credit Card (provide information below) ○ Payment by Check or Money Order

○ MasterCard ○ Visa ○ Discover ○ American Express

Credit Card # **Exp. Date** (MM-YYYY) –

Credit Cardholder Signature _____

This credit card will be billed for drug costs, expedited shipping (if applicable) and any outstanding balances. It will also be billed for all future orders, unless you provide a different form of payment.

By returning this form to Caremark, 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 healthcare providers/agents for health benefits management.