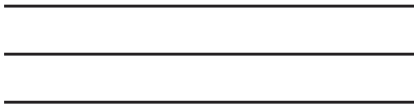


MLR-WLPMSN (STL MAILER) JAB11492 REV 01/27/2010



Postage
Required
Post Office will
not deliver
without proper
postage



EXPRESS SCRIPTS®

**HOME DELIVERY SERVICE
PO BOX 66558
SAINT LOUIS MO 63166-6588**



Express Scripts New Patient Home Delivery Form

1. Ask your doctor to write your prescription quantity for a 90-day supply.
 2. Use **ALL CAPITAL LETTERS** in **BLACK INK**. Fill in the ovals as shown (●).
 3. To avoid delays, please include this completed form with your first order. Standard shipping is FREE and should arrive within 14 days from the date we receive your order.
- Fill in this oval if you have more than two family members. Write their name, date of birth, gender, allergy and health conditions along with doctor information on a separate sheet of paper.



1041

ID Card Number

Grid for ID Card Number: 12 columns of boxes.

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

Grid for First Name, MI, and Date of Birth.

Last Name

Grid for Last Name and Gender (M/F).

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Shipping Address 1

Grid for Shipping Address 1.

Shipping Address 2

Grid for Shipping Address 2.

City

Grid for City and State.

Zip Code

Grid for Zip Code.

● Check here for rush shipment. Your order, once received and filled, will be shipped overnight for \$21.

Email

Grid for Email address.

Please select one as your preferred telephone number

Form for selecting preferred telephone number (Daytime, Evening, or Cell Phone).

Doctor/Prescriber Last Name

Grid for Doctor/Prescriber Last Name.

Doctor/Prescriber Phone Number

Grid for Doctor/Prescriber Phone Number.

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

Grid for Patient 2 First Name, MI, and Date of Birth.

Last Name

Grid for Patient 2 Last Name and Gender (M/F).

Email

Grid for Patient 2 Email address.

Doctor/Prescriber Last Name

Grid for Patient 2 Doctor/Prescriber Last Name.

Doctor/Prescriber Phone Number

Grid for Patient 2 Doctor/Prescriber Phone Number.

All individuals included in the family will be charged to this credit card.

Form for selecting payment method (Apply to this order only, Apply to all orders, Check Card, Credit Card, Check / Money Order).

Amount Enclosed

Grid for Amount Enclosed (\$).

Card #

Grid for Card Number.

Exp. Date (MM/YY)

Grid for Expiration Date.

Sign here to authorize card payment X

PATIENT 1 (CARDHOLDER)

PATIENT 2

PAYMENT

Detach Here

Detach Here



1042

Patient 1 (Cardholder)

Name: _____

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)
[][] / [][] / [][][][]

Date of Birth is required for patient identification.

Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

Patient 2

Name: _____

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)
[][] / [][] / [][][][]

DRUG ALLERGIES

List other Allergies here:

- No Known Allergies**
- Acetaminophen/Tylenol®
- Amoxicillin
- Aspirin
- Cephalosporin (i.e., Keflex®, Cephalexin)
- Codeine
- Erythromycin, Biaxin®, Zithromax®
- NSAIDs (i.e., Ibuprofen, Naproxen)
- Oxycodone (i.e., OxyContin®, Percocet®)
- Penicillin
- Sulfa
- Tetracycline (i.e., Doxycycline, Minocycline)

List other Allergies here:

HEALTH CONDITIONS

List other Health Conditions here:

- No Known Health Conditions**
- Arthritis (715.9)
- Asthma (493.9)
- Chronic Bronchitis or Emphysema (496)
- Depression (311)
- Diabetes Type I (250.01)
- Diabetes Type II (250.00)
- Epilepsy/Seizures (345.9)
- GERD (530.81)
- Glaucoma (365.9)
- High Cholesterol (272.9)
- Hormone Replacement Therapy (627.9)
- Hypertension (401.9)
- Thyroid: Low (244.9)

List other Health Conditions here:

OTC

List other OTC that you take on a regular basis:

- No Over-the-Counter Medications**
- Acetaminophen/Tylenol®
- Advil®/Aleve®/Motrin®
- Aspirin/Excedrin®

List other OTC that you take on a regular basis:

DEVICES

List Medical Devices here:

- No Medical Devices**
- Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.

List Medical Devices here:

OTHER

List other Prescription Medications here:

- No Other Prescriptions**
- Prescription Medications not filled through Express Scripts Pharmacy.

List other Prescription Medications here:

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required _____