

NEW PRESCRIPTION MAIL-IN ORDER FORM

Member ID Number								
(Additional coverage, if	applicable) Se	econdary	Mem	ber ID Number				
Last Name				First Name			MI	
Delivery Address						Apt. #		
City				State ZIP		ZIP		
Phone Number with Are	a Code							
Date of Birth (mm/dd/yy	Gender	nder Email M O F						
Physician Name			· 1					
Physician Phone Numbe	r with Area C	ode						
Health history	,							
Medication Allergies: O None known O Amoxil/Ampicillin	O Aspirin O Cephalosp O Codeine	O Erythromycin porins O NSAIDs O Penicillin		AIDs	O Quinolones O Sulfa O Tetracyclines		O Others:	
Health Conditions: O None known O Arthritis	O Asthma O Cancer O Diabetes	O Glaucoma O Heart conditior O High blood pre		art condition	O High cholesterol O Osteoporosis O Thyroid Disease		O Others:	
Over-the-counter/herb		ons take						
Payment and	shipping	inforn	natio	n — do no	t send ca	sh		
Standard delivery is inclu complete order. OptumR	ded at no cha x will contact	arge. Pres t you if th	criptio iere wi	ns from Optum ill be an extend	nRx should a ed delay in c	rrive within 5 Ielivering you	business days after v r medications.	<i>v</i> e receive the
Visit the URL listed on th may not be returned for	e back of you a refund or a	ır membe djustmer	er ID ca nt.	ard to check dru	ug pricing be	efore sending	payment. Once shipp	ed, medications
Ship overnight. Add \$12.50 to order amount (subject to change).			New Credit Card Number					
 Check enclosed. All signed and made paya Charge to my credit 	mRx. Expiration Date			ate (Month/Y	'ear)	Visa, MasterC and Discover	Card, AMEX are accepted.	
○ Charge to my NEW								
Signature:			<u>(11)</u>			<u> </u>	Date:	
For new prescription ord related to prescription or payment method for a	ders. By supp	lying my	credit	card number, I	authorize (OptumRx to	maintain my credit	
Mail this com	pleted or	der fo	m w	ith your n	ew presc	ription(s)) to OptumRx, I) THE ORDER FC	

