

YOUR PATIENT WOULD LIKE TO RECEIVE THEIR PRESCRIPTION MEDICATION FROM MEDCO.

34202



Please complete ALL information below. Incomplete forms cannot be processed. Please print clearly.

STEP 1 ▶ Prescriber Information

Questions? Call 1.888.EASYRX1

Note to Prescriber	
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Prescriber Name _____

DEA _____
Required for CIII-CV medications

Secure fax number _____

NPI ▶ _____

STEP 2 ▶ Member Information

Member No.

8	4	5	2	2	5	4	3	6
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(Include all characters. Leave box blank for spaces)

Member Name(card holder): _____

STEP 3 ▶ Patient Information

Patient Name	
DOB	Tel
Ship to address	

- Allergies**
- None Sulfa Penicillin
- Aspirin Codeine Iodine
- Other _____

- Medical Conditions**
- Heart Failure Hypertension
- Heart Attack/Angina Asthma
- Glaucoma Ulcer
- Other _____

STEP 5 ▶ Return Fax

NO COVER SHEET REQUIRED
Fax this page ONLY to
1 800 837-0959

- ▶ Medco cannot accept CII prescriptions via fax
 - ▶ Fax forms will only be accepted when sent from a prescriber's office
 - ▶ The printed fax confirmation is proof of receipt
- Most patients can receive a 90-day supply plus refills up to 1 year where appropriate.**

STEP 4 ▶ Prescription Information

Please complete or attach prescription below

<p>Prescriber Name Address City, State, Zip Telephone</p>	<div style="border: 1px solid black; height: 100px; width: 100%;"></div>
<p>Patient Name _____</p> <p>DOB _____ Issue Date _____</p>	
<p>R_x</p>	
<p>Refills _____</p>	
<p>_____ Prescriber Signature</p>	
<p>Substitution Permissible _____</p>	
<p>_____ Prescriber Signature</p>	
<p>Dispense as Written _____</p>	
<p>(We cannot accept Signature Stamps)</p>	

