FOLD BACK HERE

Medco Health Home Delivery Pharmacy Service™ Order Form

Benefits Provided by Comfort Systems

For Refills

To order from our website: **www.medcohealth.com.** Have your member ID number and Prescription (Rx) number on hand. You can find your member ID below, and your 12-digit Prescription or Rx number can be found on your refill slip.

To order by phone: Call **1 800 4REFILL (1 800 473-3455)** to use the automated refill system. Have your member ID number and your refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For New Prescriptions

Fill out one line of the Patient Information Section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number.

For All Home Delivery Orders

Place all prescriptions and refill slips together with this completed order form and your co-payment in the enclosed return envelope. Be sure to fold the form as indicated so the address on the bottom right shows through the window.

If You Need Additional Help

Call Member Services at **1 800 711-0917.** Best times to call are Tuesday through Friday afternoons.

See the back of this form for additional instructions.

Member Information

Member ID:
Group: CSUSARX

Name: ____________________
Street Address: ____________________
Street Address: ____________________
Street Address: ____________________
City, ST, ZIP: ____________________

Daytime telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Evening telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Shipping address if different from your mailing address
Check if ☐ Temporary ☐ Permanent

____
____
____

You authorize release of all information to the plan administrator, sponsor, or their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of you or your family members.

FOLD BACK HERE

Patient Information—Complete one line for each new prescription *(Do not complete for refills)*

Patient name	Patient's relation to plan member *(fill in one)*	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1	Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
2	Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
3	Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No

Order Information

Total number of medications in this order ☐
(including all refills and new medications)

Subtotal of this order $☐☐☐.☐☐

Optional expedited shipping
$9.00 (subject to change) ☐☐.☐☐

Total enclosed
(do not send cash) $☐☐☐.☐☐

Paying by credit card? ☐Visa ☐MC ☐Disc/NOVUS ☐AmEx ☐Diners

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
CREDIT CARD NUMBER

M☐☐ Y☐☐
EXPIRATION DATE

X ____________________
CARDHOLDER SIGNATURE

☐ **Check here to have all orders billed to your credit card.** By doing so, you authorize Medco Health to keep your card number on file and bill all future orders directly to your credit card. To enroll by phone, please call 1 800 948-8779.

Paying by check? Write your member ID on your check or money order made payable to Medco Health.

Please be sure address is visible through window of return envelope

MEDCO HEALTH
PO BOX 650322
DALLAS, TX 75265-0322

FORM #HB12411S

Please take a minute to make sure...

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your member ID on any check or money order.**
- **The Medco Health address on the front shows through the window of the return envelope.**
- **You have filled out the Health, Allergy, and Medication Questionnaire. This information will help Medco Health better serve your prescription drug needs.**

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered to your area. This option must be chosen when you make the order and cannot be applied after an order is already processed.

Additional Instructions

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all Home Delivery Pharmacy Service orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If you do, once your unpaid balance exceeds that limit no additional orders will be processed until the balance is paid.

You can call 1 800 948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Texas law allows a less expensive, generically equivalent drug to be substituted for certain brand name drugs unless your physician directs otherwise. You have a right to refuse such substitution. Consult your physician or pharmacist concerning the availability of a safe, less expensive drug for your use.

A pharmacist is available during normal business hours to answer questions concerning your prescription.

Get more information from our website.

Visit us at **www.medcohealth.com.**

Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

medco®

Member/Subscriber Information *See your prescription drug ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City ______ State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Nonspouse Partner
- ☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City ______ State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Medco or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X ______________________
Signature of Pharmacist or Representative **(Required)**

NABP Number Required

Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND SUBMISSION

☐ **Medication purchased outside of the United States**
Please indicate:

Country ______________

Currency used ______________

☐ **Allergy medication**

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape receipts on the back.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X ______________________
Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.
Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.
Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11 digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity
Total Quantity	
Total Charge	

Direct Reimbursement Claim Instructions
Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid full price for a prescription drug order at a pharmacy because:
   - The pharmacy does not accept your Medco prescription drug ID card, or
   - You have not received your Medco prescription drug ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within 1 year of date of purchase or as required by your plan.
5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, then sign and date this form.
7. Return the completed form and receipt(s) to:

   Medco Health Solutions, Inc.
   P.O. Box 2187
   Lee's Summit, MO 64063-2187

* California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Visit us online anytime at **www.medco.com**.

medco®