Toll Free 1-866-744-0621
www.medvantxrx.com

MEDVANTX®
Pharmacy Services

ORDER FORM (Part A)

Toll Free 1-866-744-0621
www.medvantxrx.com

Please Read

- ◊ Please complete the information on Parts A, B & C of this form (as appropriate). The health history grid (Part C) should be completed for each patient submitting a new prescription for the first time or to make changes for active patients.
- ◊ It is important to include a telephone number in the Member Information area (Part B) in case we have questions about your order.
- ◊ Please complete the payment options section (below). Failure to complete will result in a delay in the processing of your order.
- ◊ Please use a black or blue pen to complete this form. Our mailing address is: **MedVantx Pharmacy Services**
  PO Box 5736
  Sioux Falls, SD 57117-5736
  www.medvantxrx.com

REFILL OPTIONS (OF EXISTING PRESCRIPTIONS ON FILE WITH MED VANTX)

1. **FOR FASTER SERVICE, PLEASE VERIFY AVAILABLE REFILLS AND CALL US TOLL FREE AT 1-866-744-0621.**
2. Complete payment information and mail to us.
   Payment is required on all orders prior to shipping medications
3. Complete REFILL section below including payment information.

Patient _____	Patient _____	Patient _____
Rx # ☐☐☐☐☐☐☐☐	Rx # ☐☐☐☐☐☐☐☐	Rx # ☐☐☐☐☐☐☐☐
Rx # ☐☐☐☐☐☐☐☐	Rx # ☐☐☐☐☐☐☐☐	Rx # ☐☐☐☐☐☐☐☐
Rx # ☐☐☐☐☐☐☐☐	Rx # ☐☐☐☐☐☐☐☐	Rx # ☐☐☐☐☐☐☐☐

TO FILL NEW PRESCRIPTIONS (PLEASE INCLUDE YOUR HARD COPY PRESCRIPTIONS)

Patient Name	Date of Birth	Relationship			*(Check One)*		Brand Only*	Medication Name	Prescribing Physician Name
		Self	Spouse	Other	Fill Now	Place on File			
							❑		
							❑		
							❑		
							❑		

* I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate, unless the above box is checked. By checking that box, a higher copayment amount may apply.

PAYMENT OPTIONS

Payment to MedVantx is due with each order. Do not send cash. Refer to your benefit materials for copayment amount. **"Thank you for choosing MedVantx".**

For fastest service, paying by credit card is our preferred payment method.

❑ Mastercard ❑ Visa ❑ American Express ❑ Discover ❑ Use credit card on file

Account # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date ☐☐/☐☐

If you use a credit card for your payment, MedVantx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Cardholder's Signature _____ ☐ Please keep this credit card on file for future orders.

Check # ☐☐☐☐☐ Money Order # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Check or money order amount $ ☐☐☐☐.☐☐

Please write your cardholder ID number on your check or money order. There is a $30.00 returned check charge.

Delivery: Please allow 14 days from the date you mail your order for delivery of your medicine.

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MEMBER INFORMATION (Part B)

(Please complete with each order using black or blue ink)

Cardholder ID # (Refer to ID Card) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Group # (Refer to ID Card [if applicable]) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐

Last Name of Cardholder First Name of Cardholder MI

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Delivery Address (**Note:** Check this box _____ if remaining info is same as previous orders and proceed to "Health History Section")

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City State ZIP

Above address is for: (check only if applicable) _____ *this order only* _____ *permanent address change*

☐☐☐–☐☐☐–☐☐☐☐ ☐☐☐–☐☐☐–☐☐☐☐

Daytime Phone Evening Phone

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

E-mail Address *(Providing your e-mail address authorizes us to e-mail you information about your MedVantx account. This information is confidential and not shared with other entities.)*

HEALTH HISTORY (Part C)

Please Complete This Health History Grid With Your First Order Or As Information Changes

Please complete information for you and all covered family members. If you are unsure about any health conditions, check with your Doctor. This portion will not be required on subsequent orders unless there have been changes in health or coverage status.

❑ Check here if information has changed.	Name (First, Middle, Last)	Birth Date (MM/DD/YYYY)	M / F	ALLERGIES: No Known Allergy	Aspirin Allergy	Penicillin Allergy	Sulfa Allergy	Other Allergy*	HEALTH CONDITIONS: Diabetes	Epilepsy	Glaucoma	Heart Condition	High Blood Pressure	Thyroid	Ulcer	Other** Condition
Member																
Spouse																
Dependent																
Dependent																

If you have additional dependents or require more space, please attach a separate note.

***Please indicate "Other Allergy"** ****Please indicate "Other Conditions"**

_____ _____

Current medications including over the counter medications / patient name _____

_____

_____

_____

_____

I represent that the information on this form is correct, and I authorize the release of information regarding medical and prescription drug history and treatment to MedVantx Pharmacy Services.

Signature _____ Date _____