



Order Form

Detach and return along with your prescription(s) and any necessary co-payment in the postage paid envelope.

INSURED FAMILY MEMBER'S NAME _____ SOCIAL SECURITY NO. _____

PLAN NAME _____ MEMBER ID NO. _____ GROUP NO. _____

SHIP TO:

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE CHECK THE APPROPRIATE DESIGNATION: ; PERMANENT ADDRESS ; SEASONAL ADDRESS ; TEMPORARY ADDRESS

HOME PHONE _____ WORK PHONE _____

COMMENT/REFILL REQUESTS:

Provide prescription numbers for refill and/or any other information to help insure the accurate and timely processing of your order.

PRESCRIPTIONS ENCLOSED FOR:

NAME _____ DATE OF BIRTH _____ I.D. NO. _____

RELATIONSHIP TO INSURED: ; SELF ; SPOUSE ; DEPENDENT SEX: ; M ; F

NUMBER OF PRESCRIPTIONS ENCLOSED (INCLUDE BOTH NEW AND REFILL) _____ TOTAL CO-PAY (THIS INDIVIDUAL) _____

PRESCRIPTIONS ENCLOSED FOR:

NAME _____ DATE OF BIRTH _____ I.D. NO. _____

RELATIONSHIP TO INSURED: ; SELF ; SPOUSE ; DEPENDENT SEX: ; M ; F

NUMBER OF PRESCRIPTIONS ENCLOSED (INCLUDE BOTH NEW AND REFILL) _____ TOTAL CO-PAY (THIS INDIVIDUAL) _____

METHOD OF PAYMENT:

TOTAL COPAY (ENTIRE ORDER) _____ ; CHECK OR MONEY ORDER ENCLOSED (MAKE PAYABLE TO HEALTH DIRECT PHARMACY SERVICES)

; AMERICAN EXPRESS ; VISA ; MASTERCARD ; DISCOVER ; KINNEY COURTESY CARD

CARD NUMBER _____ EXPIRATION DATE _____

CARDHOLDER SIGNATURE _____