Directions: Please print in **BLUE** or **BLACK** ink, using all **CAPITAL** letters.

miRx prescription mail order

Patient Profile and Prescription Order Form

Member Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____

ID Number (located on card) _____

Group Number _____

Last Name _____

First Name _____

Mailing Address _____

Physical Address (If different from Mailing Address) _____

City _____ State _____ Zip Code _____

Please Complete

Allergies
- ☐ Aspirin
- ☐ Cephalosporin
- ☐ Codeine derivatives
- ☐ Morphine derivatives
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ None known
- ☐ Other (use lines below)

_____

_____

Health Conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hypertension
- ☐ Pregnancy
- ☐ Thyroid disease
- ☐ None known
- ☐ Other (use lines at left)

I would prefer my prescription bottles to have easy open caps ☐YES ☐NO

Email-Address (to receive information regarding the processing of your order) _____

Home Phone _____

Work Phone _____

Cell Phone _____

Preferred Method of Communication (if by phone, specify which number): _____

Additional Services Available: ☐ Auto Refill ☐ Text Message (when prescription is complete) ☐ Email Notifications (when prescription is shipped)

Cell Phone Carrier
- ☐ Verizon ☐ AT&T
- ☐ Sprint ☐ T-Mobile
- ☐ Other _____

For text message notification only

Dependent Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____

Dependent Last Name _____

Dependent First Name _____

E-mail Address (to receive information regarding the processing of your order) _____

Alternate Phone _____

Cell Phone _____

Additional Services Available: ☐ Auto Refill ☐ Text Message (when prescription is complete) ☐ Email Notifications (when prescription is shipped)

Cell Phone Carrier
- ☐ Verizon ☐ AT&T
- ☐ Sprint ☐ T-Mobile
- ☐ Other _____

For text message notification only

Please Complete

Allergies
- ☐ Aspirin
- ☐ Cephalosporin
- ☐ Codeine derivatives
- ☐ Morphine derivatives
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ None known
- ☐ Other (use lines below)

_____

_____

Health Conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hypertension
- ☐ Pregnancy
- ☐ Thyroid disease
- ☐ None known
- ☐ Other (use lines at left)

I would prefer my prescription bottles to have easy open caps ☐YES ☐NO

Member Alternate Shipping Information

This is alternate shipping information for a member's medication. If a dependent's medication needs to be delivered to a different address, please specify below or contact m*i*Rx at 1-866-894-1496.

☐ This shipment only ☐ Temporary address change indicated to the right Start Date _____ End Date _____

Patient Name

_____

Alternate Mailing Address

_____

City _____ State _____ Zip Code _____ Alternate Phone Number _____

Payment and Shipping Information

By submitting this form, you hereby authorize release of all information to m*i*Rx as required to process your order under your benefit plan. Please enclose your prescription with this form.

Total number of prescriptions this order..... _____

☐ Regular Shipping.....$ NO CHARGE
☐ Next Business Day ($19.00).....$ _____ . _____
☐ 2nd Business Day ($12.00).....$ _____ . _____

Total Shipping Cost.....$ _____ . _____

Price of shipping may change by carrier without notification and may vary depending on weight and zone.

SEND TO:
MAIL: miRx, P.O. Box 21669, Billings, MT 59104;
EMAIL (scan form first): miRx@ebms.com or
PHONE: 1-866-894-1496
FAX: 1-406-869-6552

Payment Options (to pay over the phone, call 1-866-894-1496)

☐ Check made payable to m*i*Rx
☐ Charge credit card listed below for this order only
☐ Charge credit card listed below for this and all future orders

☐ American Express ☐ Visa ☐ Discover ☐ MasterCard

Credit Card Number _____

Expiration Date _____/_____

PLEASE READ AND SIGN: I certify that the information provided on this form is current; and I authorize m*i*Rx Pharmacy to substitute generic drugs in all cases when legally permissible, in accordance with applicable law, consistent with my doctors order.

_____ _____
Member/Cardholder Signature Date