HOME DELIVERY ORDER FORM





1 Member information: Please verify or provide me	ember information below.					
Member ID: Group:	☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: @					
Name:Street Address:	New shipping address: (Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.					
Street Address:City, ST, ZIP:						
Daytime phone:	Evening phone:					
	on for each person with a prescription. If a person has a new section for each doctor (additional sections are on					
First name Last na	me					
	c's relationship to member ☐ Spouse ☐ Dependent					
Doctor's last name	1st initial Doctor's phone number					
First name Last na	me					
	z's relationship to member ☐ Spouse ☐ Dependent					
Doctor's last name	1st initial Doctor's phone number					
payable to Express Scripts, and write your member II	money order, or credit card. Make checks and money orders D number on the front. You can enroll for e-check payments Member Services phone number found on your ID card.					
Number of prescriptions sent with this order:						
Payment options: □e-check □Payment enclosed □	Credit card □Send bill					
For credit card payments: ☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners	Credit card number					
Expiration date M M Y Y Cardholder signature	☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.					
☐ Rush the mailing of this shipment (\$21, cost subjet not the processing of your order. Street address is						

STLT2NWB

First name		Last n	ame							
Birth date (MM/DD/YYYY)	Sex		nt's relatio	•						
	☐ M ☐ F	Se	If Spo	use	Depe	ndent				
Doctor's last name				1st i	nitial	Docto	r's pho	one nu	ımber	
First name		Last n	ame							
Birth date (MM/DD/YYYY) Sex			nt's relatio							
Doctor's last name				1st i	nitial	Docto	r's pho	one nu	ımber	
Important reminders and o	ther inform	ation								
Check that your doctor has prescribed supply allowed by your plan (not a refills for up to 1 year, if appropriator pharmacist about safe, effective generic drugs	a 30-day suppl ate. Also, ask y	y), plus our doctor	of med directs	riate by ication, otherw	law, to unless ise.	o substi you or	itute g your d	eneric doctor	form specif	ulations ically
supply allowed by your plan (not a refills for up to 1 year, if appropria	a 30-day supplete. Also, ask yee, and less expendedication Quellance that you es you over the east in processing tion 3 for detablementiciary All k your prescripties. Or, call Mound on your I	ly), plus our doctor densive estionnaire. I can carry limit, you ag by using hils.) ND have otion drug o get ember D card.	approp of med directs Penr substitu brand-n Check t brand o Please n any refil For add Express- number 1.800.7	riate by ication, otherw asylvania te a less ame druche box or gene tote that ils of that ils of that if ional is 55.108	law, to unless ise. and Te expense gunless if you ric drug this apt to prescriform from on you 9.	xas laws ive gene s you or do not g. plies onl iption. aation o call Mer	s permi eric equ your do wish a ly to ne or help, mber S d. TTY/	eneric doctor t pharr uivalen octor di a less o ew pres visit us ervices TDD us	formi specif macists t for a rects o expen scriptio	ulations ically to therwise.

Place your prescription(s), this form, and your payment in an envelope. Do not use staples or paper clips.

EXPRESS SCRIPTS PO BOX 66567 ST. LOUIS, MO 63166-6567