

Member Enrollment Form

MEMBER INFORMATION

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

DELIVERY ADDRESS (Please use current address)

Address 1 (Street Address)		
Address 2 (Apartment #, Suite #, Etc)		
City	State	Zip
Home Phone	Work Phone (Include area code)	
Email Address (Optional)		

SPOUSE INFORMATION

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

DISCOUNT CARD INFORMATION

Member ID	Group ID	BIN
-----------	----------	-----

PAYMENT OPTIONS (Filing purposes only. Payments due at time of order.)

Please indicate your choice by checking the appropriate box.

CREDIT CARD

Name On Card

Card Number

Expiration Date (MM / YY)

DIRECT FROM MY BANK ACCOUNT

Account Type

Checking Savings

Account Number

Routing Number (The 9-digit number on the bottom of your check or deposit slip. If you are unsure, please ask your financial institution what your routing number is.)

* If you are enrolling for ACH debiting, please include a voided check or encoded deposit slip with this form.

CHECK / MONEY ORDER Submit your check or money order at time of order.

DEPENDANT INFORMATION

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Please sign and date below to complete the enrollment.

I certify that the information on this form is correct, and authorize release of information regarding my medical and prescription drug history to the program sponsor of the prescription drug program.

Member's Signature _____

Date _____

INSTRUCTIONS FOR ORDERING YOUR MAINTENANCE MEDICATIONS

Welcome to Express Med Pharmacy Services Mail Service Program! Use the convenience of your mail order prescription drug program if you are taking medications to treat any on-going health condition such as diabetes, asthma, or high blood pressure. Ordering 90-day maintenance supplies can save you significantly on brand and generic medications.

There are several methods for placing new orders and refilling existing orders with Express Med Pharmacy Services (EMPS). Simply select the method that best suits your needs.

ORDERING NEW MEDICATION

FOR MAINTENANCE MEDICATIONS (high blood pressure, high cholesterol, diabetes) :

BY MAIL

Have your doctor write a prescription for up to a 90-day supply of your medication and appropriate refills for up to one year. Then mail your prescription(s) and payments to:

Express Med Pharmacy Services
3950 Brodhead Rd
Monaca, PA 15061

BY FAX

Have your doctor call 1-866-462-4579 to obtain fax instructions and forms.

You then complete the enclosed Member Enrollment Form, and Mail Service Prescription Order Form, and mail them along with your payment to EMPS. If you don't have a credit card on file please contact us to find out your prescription pricing.

REFILLING YOUR MEDICATION

BY MAIL

Mail refill ticket with applicable payment to EMPS at the address indicated on the form.

BY PHONE

Call 1-866-462-4579 and follow the automated instructions. Must have credit card information on file.

ONLINE

Log on to www.expressmedrx.com and look for Mail Order Services. Follow the links to the online refill instructions. Must have credit card information on file.

- NOTICE -

Be sure to place your refill orders 14 days before you run out of your current medication supply. You can locate your refill due date on your refill ticket that comes with every order or on the bottom of your prescription label.

INSTRUCTIONS - Continued

DELIVERY OF YOUR MEDICATION

Medication orders receive prompt and immediate attention. Following the receipt, verification, authentication, numerous cross-checks for quality assurance and final processing of each order your medications are sent to you via USPS, UPS, or FedEx.

Most often your medication will be delivered to your home in 7-11 days after you mail your order. If you place your prescription order via telephone, fax, or internet, they may be received even faster. Express Med provides free standard shipping for prescriptions. If you choose to have your medication shipment rush-ordered, additional charges will apply.

PAYMENT FOR YOUR MEDICATION

You may pay for your order by Visa, Mastercard, Discover, and American Express. If you know your payment you may also pay by personal check or money order; however, these methods may delay processing. If paying by credit card consider enrolling in our "Automatic Payment Plan". Your credit card will automatically be billed each time an order is processed and delivered to you. Call 1-888-350-MEDS (6337) today to activate your account for the automated payment plan.

Please Note: If you do not have a credit card on file you must send payment before orders will be mailed to you.

GENERIC SUBSTITUTIONS

It is regular practice of EMPS to substitute generic equivalents for brand-name medications whenever possible. EMPS will dispense an FDA approved generic equivalent when available, as permitted by your doctor and allowable by law. From time to time your doctor may prescribe a medication to be dispensed as written when a preferred brand name or generic medication is available. As part of your mail order benefit program, the pharmacist may discuss with your doctor whether the alternative medication may be appropriate for you. The doctor always makes the final decision as to what medication you receive. If you do not want a generic equivalent please contact EMPS. Generic medications are manufactured under the same FDA guidelines as their brand-name counterparts, contain the same active ingredients, and are safe and effective. Generic medications typically cost less than brand name medications, resulting in cost savings. Please ask your doctor to prescribe generic drugs whenever applicable.

CUSTOMER SERVICE CALL CENTER

EMPS functions as an informational resource available to address all or your mail order pharmacy questions and/or concerns. Feel free to contact an EMPS Representative toll free at 1-866-462-4579 to help assist you in addressing your long-term medication management needs.

Prescription Order Form

HOW TO ORDER

For New Prescriptions

Complete a separate order form for each individual ordering new medicine. Be sure to include the new prescription(s) from your doctor along with the applicable payment due.

For Refill Prescriptions

By Phone: Call 1-866-462-4579 and have your Member ID and the refill prescription(s) information available.

By Mail: Complete a separate order form for each individual and return the refill slip(s) and payment to the address above.

By Web: Log onto expressmedrx.com and click the REFILL link.

MEMBER INFORMATION

First Name | MI | Last Name

DELIVERY ADDRESS (Updates Only)

Address 1 (Street Address)

Address 2 (Apartment #, Suite #, Etc)

City | State | Zip

Home Phone | Work Phone (Include area code)

Email Address (Optional)

DISCOUNT CARD INFORMATION

Member ID | Group ID | BIN

ORDER INFORMATION

ORDER IS FOR Member Spouse Dependant

If not member, please provide name (ONE FORM PER PERSON):

First Name | MI | Last Name

Total Number of Prescriptions for this Person

Doctor Name | Phone Number

PAYMENT OPTIONS (Payments due at time of order.)

Please indicate your choice by checking the appropriate box.

CREDIT CARD

Name On Card (Updates Only. Do not provide if already on file.)

Card Number

Expiration Date (MM / YY)

DIRECT FROM MY BANK ACCOUNT

Account Type (Updates Only. Do not provide if already on file.)

Checking Savings

Account Number

Routing Number (The 9-digit number on the bottom of your check or deposit slip. If you are unsure, please ask your financial institution what your routing number is.)

* If you are enrolling for ACH debiting, please include a voided check or encoded deposit slip with this form.

CHECK / MONEY ORDER Submit your check or money order at time of order.

Please sign and date below to complete the enrollment.

I certify that the information on this form is correct. I authorize payment for this order as indicated above. I acknowledge that if an ACH debit or check is declined, there is a \$30.00 charge.

Member's Signature _____

Date _____

PMT.MSPOF.01.10