

REFILL REQUEST FORM: MEDCO MAKES IT EASY TO REFILL YOUR MAIL-ORDER PRESCRIPTIONS

If you have refills remaining on a current mail-order prescription, you don't need to get a new prescription.

We're happy to help you get refills of any existing prescriptions that have been transferred from your previous mail-order pharmacy to the Medco mail-order pharmacy. When you use the Medco Pharmacy, your medications are delivered conveniently and safely right to you, and you get the full support of a specialist pharmacist—someone who has received specialized training in the medications used to treat a specific condition and who has the time to talk to you about your medication.

To refill your prescription(s) through the Medco Pharmacy, choose one of the three easy methods listed below. Please have your member ID number on hand before you begin, along with the prescription number from a current mail-order prescription label or refill slip. Please request your refill when you have a 2-week supply of medication remaining. Not all refills may be available immediately, but they should be available shortly after the transition to Medco.

Online

- Visit **www.medco.com**.
- Activate your account by registering with your Medco member ID number and a recent prescription number from your previous mail-order pharmacy.
- Follow the instructions for refilling your prescriptions.

By telephone

- Call the toll-free Member Services telephone number shown on your ID card or other plan materials.
- Use our automated phone system to request your prescription refill. If you need help, you will be transferred to a Member Services representative.

By mail

- Fill out the information on the other side of this form.
- Attach your most recent refill slip(s) in the space indicated.
- Use the enclosed Medco Pharmacy Order Center envelope to mail us the completed form and your mail-order co-payment.

Please note that prescriptions for certain controlled substances and compound medications cannot be transferred. You will need to obtain a new prescription from your doctor for these types of medications. There may also be some situations where this transfer process will not be successful. If you request a refill that cannot be transferred, you will need to obtain a new prescription from your doctor.

PAYMENT INFORMATION

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Expiration date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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☒

Cardholder signature

☐ If you would like us to charge all future orders to this credit card, please place a check mark in this box.

medco[®]

MEDCO HEALTH SOLUTIONS OF FORT WORTH
P O BOX 650322
DALLAS TX 75265-0322



FORM TO REQUEST REFILLS OF YOUR MAIL-ORDER PRESCRIPTIONS

MEMBER INFORMATION

Member ID number: _____

Group number: _____

Name: _____

Street address 1: _____

Street address 2: _____

City, State, Zip: _____

Daytime telephone: - -

Evening telephone: - -

Shipping address if different from your mailing address

Check if ☐ Temporary ☐ Permanent

I understand that the information I provide may be released to and used by my health plan in connection with the benefit plan programs. Information may be used for other reporting and analysis purposes without identification of me or my family members.

Signature X _____

INFORMATION REQUIRED FOR EACH REFILL ORDER (Be sure to include a refill slip for each refill you order.)

Patient name	Patient's relation to plan member	Sex	Birth date	Doctor name and phone number	Drug name/ strength	Current prescription no.
1	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			
2	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			
3	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			

***Affix
Refill Slip(s)
Here***

***We look forward to assisting you
with your prescription needs***

Please affix your current refill slip(s) for each prescription in the space provided. Without a refill slip, your request cannot be processed. Your medication will be sent to you via U.S. mail, usually within 8 days.

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