Your Mail Service Rx Program provided by Prescription Mart

How to Order

1. Before leaving your doctor's office:
   - If you need medication on a long-term, regular basis (called maintenance medication), ask your doctor to prescribe an ample supply.
   - Make sure your doctor writes the prescription for the maximum quantity your company will allow, so you will get the most allowed by your benefit.
   - We must fill the prescriptions as they are written to be dispensed.
   - Discuss generics. Ask your doctor to prescribe generic medication whenever possible. Prescription Mart will automatically fill your order with an approved generic drug, if one is available, unless your doctor states your prescription must be "dispensed as written" (DAW) or "brand necessary."
   - If you must take your medication immediately, ask your doctor for two prescriptions - one for a 14 day supply for you to have filled at your local pharmacy. Mail the second prescription to Prescription Mart.
   - If you already have a prescription, call your physician for a new (second) prescription. Then simply mail it to us.
   - Check the prescription to be sure it clearly shows your doctor's name and address, exact dosage and patient's name. Please print the patient's name and date of birth on the back of each prescription.
   - Prescription Mart will accept a personal check, money order or major credit card. Remember to complete the Patient Profile Form and Prescription Request Form and enclose them with the appropriate co-payment and original prescription(s) in the return reply envelope. DO NOT SEND CASH. If using VISA, MasterCard or Discover, please include your card number and expiration date with your order.
   - Prescription Mart will process your order and ship it to you, along with ordering instructions and forms for refills and/or new prescriptions.

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If you take medication on a long-term, regular basis (called maintenance medication), ask your doctor to prescribe an ample supply.

Your prescriptions will be delivered by Prescription Mart. You will receive an ample supply of your medication through your current prescription drug plan. This will save you money, and will make it possible for you to receive necessary medications without going to the pharmacy. Your medications will be delivered to your home, and will be shipped directly to you or your representative. Your medications will be shipped within 7-10 days of receipt of your order, unless you otherwise specify.

Mail Service is quick, safe and reliable!

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PRESCRIPTION REQUEST FORM

Cardholder Name (Please Print)  
First  Middle Initial  Last
Shipping Address
Street  Apt  
City  State  Zip
Daytime Phone  Email Address
Payment Amount $  
☐ Apply credit balance to this order  
☐ Check Enclosed  
☐ Please charge my credit card #  
☐ Visa  ☐ Master Card  ☐ Discover  Exp. Date
I have read the CERTIFICATION STATEMENT.
I hereby certify to and accept the terms thereof.
Cardholder’s Signature  Date

MAIL SERVICE PRESCRIPTION DRUG PROGRAM
P.O. Box 12607 • Beaumont, TX 77726-2607
www.presmartinc.com

☐ Check here if using new address  
☐ Please check if you DO NOT want generic medications. (Refusal of generics may impact your copay.)  
☐ Check here if using new address  

Prescriptions for (check boxes) below. Fill in name & date of birth for dependents.

☐ Employee Date of Birth  
☐ Employee Date of Birth  
☐ Employee Date of Birth  
☐ Employee Date of Birth  
☐ Employee Date of Birth  
☐ Employee Date of Birth  
☐ Employee Date of Birth  
☐ Employee Date of Birth  

REFILL REQUEST FORM

HOW TO ORDER YOUR PRESCRIPTIONS
1. Complete the request form above. Answer all the questions and include the cardholder ID number.

2. Enclose the Prescription Request Form with every order and enclose your doctor’s original prescription for each new order. Return to Prescription Mart in the envelope supplied. Make your check or money order payable to Prescription Mart. When using a credit card, please include your card number, expiration date, and credit card holder’s name as it appears on the card.

3. If you are ordering an authorized refill of a prescription in our file, list the Rx number(s) and the medication name from your label here.

CERTIFICATION STATEMENT

IMPORTANT: I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policyholder and employer. I have read the CERTIFICATION STATEMENT and hereby certify to and accept the terms thereof.

X