Your Mail Service Rx Program provided by

Prescription Mart

If you take medication on a long-term, regular basis, this program is for YOU!

Your prescriptions will be delivered **BY MAIL**, postage paid, right to your home. No standing in the pharmacy line again!

You will receive an ample supply of your medication instead of the smaller supply available through your current Prescription Drug Plan. This **will save you several trips** to the pharmacy.

If you are currently eligible for Prescription Drug Benefits, you and your covered dependents may order prescription drugs from ***Prescription Mart.*** The medications covered by the Mail Service Prescription Program are the same as your present Prescription Drug Plan.

You'll receive generic medications when available. Generics are approved by the FDA and are as safe, potent and effective as their brand name counterparts.

Refrigerated items require special handling and will be shipped only at patient's expense. We recommend you get these items locally, but we can accommodate these needs at your expense if you wish. Please advise us on these items each time you order.

Mail Service is quick, safe and reliable!

You will receive your medication at your home via U.S. Mail, United Parcel Service, or Fed-Ex within 10 to 14 working days from the date we receive your order.

Your prescription is **triple checked** by licensed pharmacists and screened against your personal medical history for your protection.

Pharmacists and Friendly Customer Service people are only a toll free call away. ☎

☞ 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.

PATIENT PROFILE FORM

For your safety, we maintain a Patient Profile Record, so please complete and return with first order.

❑ *Male* ❑ *Female*

Employer _____ Daytime Phone _____

Cardholder Name (Please Print) _____ Alternative Phone _____
First *Middle Initial* *Last*

Shipping Address _____ Date of Birth _____
Street *Apt*

_____ Dr.'s Name _____
City *State*

Describe cardholder's condition of allergies, chronic diseases or sensitivity to drugs. ❑ **Check here if none** Dr.'s Phone _____

Dr.'s Fax _____

★ ***List all eligible dependents on form below*** ★

I certify the information on this form is correct, and authorize release of all information to Plan Administrator.

Cardholder ID # _____

Group # _____

_____ _____
Cardholder's Signature *Date*

PLEASE FILL OUT THIS SIDE OF CARD COMPLETELY

List eligible dependents below.

Patient's NAME _____ RELATIONSHIP _____ DATE OF BIRTH _____ SEX _____
Patient's ALLERGY/SENSITIVITY/CHRONIC DISEASES _____ DR.'S NAME/PH/FAX _____

Patient's NAME _____ RELATIONSHIP _____ DATE OF BIRTH _____ SEX _____
Patient's ALLERGY/SENSITIVITY/CHRONIC DISEASES _____ DR.'S NAME/PH/FAX _____

Patient's NAME _____ RELATIONSHIP _____ DATE OF BIRTH _____ SEX _____
Patient's ALLERGY/SENSITIVITY/CHRONIC DISEASES _____ DR.'S NAME/PH/FAX _____

If there are no allergies, chronic diseases or drug sensitivity, please check "none": ❑ **NONE**

Mail To: **PRESCRIPTION MART P. O. BOX 12607 BEAUMONT, TX 77726-2607**

PRESCRIPTION MART

A Low Cost
Prescription Drug program

For Those with Long-Term Medication Needs.

- Prescriptions Delivered to your Home
- Lower out-of-pocket expense per prescription

Administered by:

Script Care, Ltd.

www.presmartinc.com

For Re-Orders

You must notify ***Prescription Mart*** either by telephone or mail to receive an authorized refill of medication currently on record. Re-order envelopes will be included with your first and subsequent orders. Refills may be dispensed only 30 days prior to the depletion of your present supply.

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Telephone Orders: Please provide the patient's name and the prescription number from the label to be filled. Notify us of how you will be paying at this time. **AUTOMATED ORDERING BY PHONE.**

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Orders by Mail: Please provide the information detailed on the prescription request form you will receive with your first order. Enclose the same amount that you sent with your first order and you will be notified if an additional payment is due.

Remember: You must enclose some form of payment. We do not bill.

Toll Free Number: 1-800-713-1230
Fax Number: 1-409-866-1317

Customer Service Hours (Central Time):
Monday - Friday 8:00 a.m. to 5:00 p.m.
Closed on Major Holidays

PRESCRIPTION MART
P. O. Box 12607 • Beaumont, TX 77726-2607
(800) 713-1230

Written information about this prescription has been provided for you. Please read this information before you take the medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer these questions.

Informacion por escrito acerca de esta receta se le a presentado a usted. Favor de leer esta informacion antes de tomar el medicamento. Si usted tiene peguntas tocante esta receta, un farmaceutico estara presente durante horas de negocio para contestar sus preguntas.

Complaints concerning the practice of pharmacy may be filed with the Texas State Board of Pharmacy, William P. Hobby Bldg. Ste 3-600, 333 Guadalupe, Box 21 Austin, TX 78701-3942, (512) 305-8000.

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 # _____
Name as it appears on 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 X _____ Date _____

MAIL SERVICE PRESCRIPTION DRUG PROGRAM
c/o Prescription Mart
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 for easy open caps
Total number of RX's requested _____
Cardholder's ID # _____

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

❑ Employee _____ Date of Birth _____
❑ Spouse _____ Date of Birth _____
❑ Son _____ Date of Birth _____
❑ Daughter _____ 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 _____