PRESCRIPTIONMART

PATIENT PROFILE/MEDICATION ORDER FORM INSTRUCTIONS

New Patients: If you are requesting a prescription, **fill out Sections 1-2 and 4-6** on the attached form and return it, following the instructions at the bottom of the page. If you want to enroll but are not requesting prescriptions to be filled at this time, **complete only Sections 1, 2 and 6.** Complete a separate form for each patient.

Returning Patients: Fill out the attached form, (make sure to include your name and date of birth in Section 2, as well as noting any changes to your current status) and return it, following the instructions at the bottom of the page.

Mail the completed form(s) to:

PRESCRIPTION MART
P.O. BOX 12607
BEAUMONT, TX 77726-2607

Note: If using the enclosed envelope, please ensure the address is visible in the window.

For faster service, you can complete this form and request prescription refills online at: www.presmartinc.com.
For questions or assistance with this form, you may contact our customer service department at: 1-800-713-1230.

MAIL ORDER FAQS

HOW DO I GET ENROLLED? Fill out the attached form or complete it online at www.presmartinc.com, and ask your doctor to send your prescriptions to our pharmacy. (Remember: We can only fill your exact prescription, so make sure your provider writes it for the maximum your plan will allow.)

WHAT IF I NEED MY PRESCRIPTION RIGHT NOW? Ask your doctor to write a 14-day prescription to fill at a local pharmacy and a longer-term one to send to us. Expedited shipping is available at an additional cost. Contact a Prescription Mart team member to set it up and we'll let you know when you can expect your order.

WHAT IF MY MEDS REQUIRE SPECIAL HANDLING? If your medications need refrigeration/special handling, a team member will contact you.

WILL YOU PROVIDE LOWER-COST ALTERNATIVES? In order to provide cost-effective quality medications, Prescription Mart may substitute FDA-approved equivalent generic medications when available unless otherwise specified by you or your prescriber.

HOW WILL YOU CONTACT ME? Our standard contact method is telephone; you can also opt for text or email. Just note it on the attached form or contact us directly and we'll enroll you in the program.

HOW DO I PAY FOR MY MEDICATION? Prescription Mart requires payment before we will ship your order; we do not bill. You can pay by personal check, money order, FSA/HRA or major credit card. Do not send cash.

CONTACT US:

Toll-free Phone:
1.800.713.1230

Fax:
1.409.866.1317

Customer Service:
Mon-Fri: 7a-6p CST
Sat: 8a-1p CST
(Closed major holidays)

Website:
www.presmartinc.com

Mailing Address:
Prescription Mart
PO Box 12607
Beaumont, TX 77726

HOW TO ORDER

ONLINE
www.presmartinc.com

NEW RX (E-SCRIPT)

Prescribers can send your prescriptions directly to the pharmacy through their electronic system:

Prescription Mart
4144 Dowlen Rd
Beaumont, Texas 77706

REFILL

Complete the Prescription Request Form online at www.presmartinc.com

PHONE
1.800.713.1230

NEW RX

Prescribers can phone in your new prescription to:

1.800.713.1230

REFILL

Request refills 24x7 with our automated ordering system or speak to a live representative Mon-Fri 7a-6p CST and Sat 8a-1p CST.

FAX

NEW RX

Prescribers can fax new prescriptions directly from their office to:

1.409.866.1317

Note: A prescription is considered a legal document. By law, we cannot accept faxed or emailed copies of prescriptions from patients.

REFILL

Complete the attached form and fax it to: .

1.409.866.1317

MAIL

NEW RX

Complete the attached form and mail it along with written prescriptions to:

Prescription Mart
P.O. Box 12607
Beaumont, Texas 77726

REFILL

Complete the attached form and mail it to:

Prescription Mart
P.O. Box 12607
Beaumont, Texas 77726

MOBILE APP COMING SOON!

Please note that you are responsible for initiating all refills with Prescription Mart per your plan design.

NEW PRESCRIPTIONS – Mail your new prescriptions with this form. Number of **NEW** prescriptions enclosed ____

REFILLS – Indicate the prescriptions to be refilled in **Section 3**. Number of **REFILL** prescriptions requested ____

1 INSURANCE INFORMATION

Identification Number:	**Group #:**	**RxBIN #:**
Cardholder's Employer:		

If your prescriptions will be filed under workers' compensation, please provide your injury date: ___/___/___ (MM / DD / YYYY)

2 PATIENT INFORMATION

◯ Check for Spanish

Patient Name: (First / Middle Initial / Last / Suffix (JR, SR))

Date of Birth: (Month / Day / Year)	◯ **Male** ◯ **Female**	◯ Check here for Easy Open caps

Home Address: (Street Address / Apt./Suite #)

City:	**State:**	**Zip Code:**

Daytime Phone #: ( ) -	**Alternate Phone #:** ( ) -

Cell Phone #: ( ) - ◯ Check to receive text notifications & alerts

Email address: ◯ Check to receive email notifications & alerts

Doctor's Name:	**Doctor's Phone #:** ( ) -

*Please complete the following medical information if you are **a new patient** or **information has changed**:*

Drug Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Latex ◯ NSAIDs
◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Medical Conditions: ◯ None ◯ Acid Reflux ◯ Anxiety ◯ Arthritis ◯ Asthma ◯ Depression
◯ Diabetes ◯ Heart Disease ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraines ◯ Osteoporosis
◯ Prostate ◯ Thyroid ◯ Other: _____

List other medications you take not filled by Prescription Mart (including over the counter supplements):

Prescription Mart may substitute FDA-approved generic medications for brand name medications unless you or your prescriber specify otherwise. If you **DO NOT** want generic medications, you must provide specific instructions (including drug names) below. **Refusal of generics may impact your copay**.

3 PRESCRIPTION REFILL INFORMATION:

To request prescription **Refills**, write the **Rx Number** and **medication name** below.

1.	2.
3.	4.
5.	6.
7.	8.

4 PAYMENT INFORMATION: AMOUNT AUTHORIZED: $_____

If your copay is $0, you do not need to provide payment information.

◯ Call me for payment information

◯ Check or money order enclosed (Payable to: Prescription Mart). Write your Member ID # on your check.
Prescription Mart may charge up to $25 for returned checks.

◯ Charge credit card on file

◯ Apply credit balance to this order

◯ Please charge the following card:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit card number: | | | | | | | | | | | | | | | | |

Expiration Date: Billing Zip Code:

Name as it appears on card:

◯ Keep this payment method on file for future orders ◯ Use this payment method one time only

DO NOT SEND CASH.

CREDIT CARD HOLDER SIGNATURE: _____ DATE: _____

5 SHIPPING ADDRESS *(if different from Home Address listed in Section 2):*

First Name / Middle Initial / Last Name

Company Name (if applicable)

Street Address

City	State	Zip Code

◯ Check here if you would like us to use this shipping address for this order only and not future orders.

◯ Check here if you would like us to contact you to schedule expedited shipping at your expense.

If your medication(s) require special handling, a team member will reach out to you to advise when delivery is expected.

6 CERTIFICATION

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 future transactions 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, policy holder and employer in accordance with the Health Insurance Portability and Acountability Act (HIPAA).

PATIENT SIGNATURE: _____ DATE: _____