Medco Pharmacy™
MAIL-ORDER FORM

UnitedHealthcare® OXFORD®

1 Customer information: Please verify or provide customer information below.

Subscriber #: ______________________

Rx Grp #: ______________________
(located under the logo on your ID card)

Name: ______________________

Street Address: ______________________

Street Address: ______________________

Street Address: ______________________

City, ST, ZIP: ______________________

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
______________ @ ______________ . ________

☐ New shipping address:

____

____

____

(Medco will keep this address on file for all orders from this subscriber until another shipping address is provided by any person in this plan.)

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Medco Health Solutions, Inc.,** and write your subscriber ID number on the front. You can enroll for e-check payments and price medications at **www.oxfordhealth.com**, or call **1-800-948-8779.**

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

Expiration date
M M Y Y

X ______________________
Cardholder signature

☐ I authorize Medco to charge this card for all orders from any person in this plan.

☐ Rush the mailing of this shipment ($15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

HG44918 5177 R.4 4/10

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

FOLD HERE

Important reminders and other information

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail-order copayment, regardless of the days' supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with three refills.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Pharmacy Customer Service number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1-800-MEDICARE (1-800-633-4227).

Medco will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name medication unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic medication.** Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at **www.oxfordhealth.com** or call the Pharmacy Customer Service number on your ID card. TTY/TDD users should call 1-800-759-1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Mailing instructions: Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P.O. BOX 747000
CINCINNATI OH 45274-7000

UnitedHealthcare®
OXFORD®

Medco Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help protect you against potentially harmful drug interactions and side effects. We will alert your pharmacist about possible drug allergies and interactions that can be harmful. To best serve you, we need to know if you have any medication allergies or medical conditions. We also need to know what prescription and nonprescription medications you take regularly.

Your privacy is important to us. We comply with federal privacy regulations and will protect this information.

Follow the steps listed below.
Step 1: Verify and complete information in SECTION 1.
Step 2: Complete all sections below using blue or black ink. Please print.
Step 3: Return the completed questionnaire in the self-addressed envelope with your mail-order form or refills. If you do not have a preaddressed envelope, please return the questionnaire to:

Medco Health Solutions, Inc.
4865 Dixie Highway
Fairfield, OH 45014
Attn: HMQ

SECTION 1: Patient information

Patient name: ____________________ Gender: ____________________

Month/Year of birth: ____________________ Contact phone: [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

Patient member number: ____________________
(Located on your ID card.)

SECTION 2: Your medication allergies

Fill in the oval **completely if you have had an allergy or serious reaction to any of these medications:**

○	Aspirin and salicylates (for example: ZORprin®, Trilisate®)
○	Codeine (for example: Tylenol® #3)
○	Erythromycin, Biaxin®, Zithromax®
○	Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, Advil®, Motrin®)
○	Penicillins/cephalosporins (for example: Amoxil®, amoxicillin, ampicillin, Keflex®, cephalexin)
○	Sulfa drugs (for example: Septra®, Bactrim®, TMP/SMX)
○	Tetracycline antibiotics
If you have an allergy to a medication that is not listed above, print the name of that medication in the space below. Example: morphine	
other:	
other:	

(over, please)

SECTION 3: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to all that apply.

⬭	Allergies, hay fever (allergic rhinitis)	⬭	Heart failure (CHF)
⬭	Arthritis	⬭	Hemophilia and hemophilia-like conditions
⬭	Asthma	⬭	High blood pressure (hypertension)
⬭	Bladder control problem (urinary incontinence)	⬭	High blood sugar (diabetes)
⬭	Brittle bones (osteoporosis)	⬭	High cholesterol (hypercholesterolemia)
⬭	Chest pain (angina)	⬭	Inflammatory bowel disease
⬭	Crohn's disease	⬭	Migraine headache
⬭	Depression	⬭	Overactive thyroid (hyperthyroid)
⬭	Emphysema (COPD, chronic bronchitis)	⬭	Peptic, stomach, or duodenal ulcer
⬭	Enlarged prostate (benign prostatic hyperplasia, BPH)	⬭	Poor circulation in the legs (peripheral vascular disease)
⬭	Gastric reflux, heartburn, or esophagitis (GERD)	⬭	Seizures (epilepsy)
⬭	Glaucoma	⬭	Stroke (TIA)
⬭	Heart attack (myocardial infarction)	⬭	Underactive thyroid (hypothyroid)

If you have a medical condition that is not listed above, print the name of that medical condition in the space below. Example: breast cancer

other:

other:

SECTION 4: Your nonprescription medications

Fill in the oval completely for each nonprescription medication that you are currently taking on a regular basis.

⬭	Advil®/ibuprofen	⬭	Prilosec OTC®/omeprazole
⬭	Aleve®/naproxen	⬭	Sominex®, Nytol®/diphenhydramine
⬭	Bayer®/aspirin	⬭	Tagamet®/cimetidine
⬭	Benadryl®/diphenhydramine	⬭	Tylenol®/acetaminophen
⬭	Orudis KT®/ketoprofen	⬭	Zantac®/ranitidine
⬭	Pepcid AC®/famotidine		

If you take a nonprescription medication that is not listed above, print the name of that medication in the space below.

other:

other:

SECTION 5: Patient prescription medications*

Please list the **prescription medications** you are currently taking in the space below. *Information can be found on the prescription labels. If none, please check here. **[ ] NONE**

Did you complete both sides? **Thank you very much.**