Blue Cross and Blue Shield of Illinois
Home Delivery Order Form — PrimeMail Pharmacy™

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

For questions about your home delivery benefits, to preregister or to download additional order forms or a physician fax form, visit the Blue Cross Web site at **www.bcbsil.com** or call customer service at **800.423.1973**.

Member and Dependent History Section information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

MEMBER AND DEPENDENT HISTORY SECTION

Member Last Name — Sex: M F

Member First Name — MI — Birth Date (MM/DD/YYYY)

Member ID Number — Group Number

PCN (lower face of ID card) — Member Phone Number

I L — – –

Delivery Address

City — State — Zip Code

Email Address

Dependent Last Name — Sex: M F

Dependent First Name — Birth Date (MM/DD/YYYY)

Email Address

Dependent Last Name — Sex: M F

Dependent First Name — Birth Date (MM/DD/YYYY)

Email Address

Dependent Last Name — Sex: M F

Dependent First Name — Birth Date (MM/DD/YYYY)

Email Address

	ALLERGIES							CONDITIONS							
	None Known	Aspirin	Codeine	Penicillin	Sulfa	Tetracycline	Other Allergy*	None Known	Diabetes	Epilepsy	Glaucoma	Heart condition	Hypertension	Ulcer	Other condition*
Member	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Dependent	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Dependent	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Dependent	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

*Please detail "other allergy" or "other condition" for each member referenced above, including related medications.

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PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **Mail** — Mail the original physician-signed prescription with this form (ask for the maximum-days supply) to: **Blue Cross and Blue Shield of Illinois, c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**
- **Fax** — Your physician can fax your prescription(s) from their office to **877.774.6360** provided you have either previously completed and submitted this form or registered at **www.bcbsil.com**

For **REFILL** prescriptions you may use either:

- **Phone** — Call our automated refill line, 7 days a week, 24 hours a day, at **877.357.7463** and follow the system prompts
- **Web** — Log on to **www.bcbsil.com** and follow the instructions
- **Mail** — Mail this completed form to: **Blue Cross and Blue Shield of Illinois, c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**

Member Last Name | Member First Name | MI

Member ID Number | Member Birth Date (MM/DD/YYYY) | Group Number | PCN (I L)

Prescription	Member	Dependent	Dependent	Birth Date (M M D D Y Y Y Y)	Physician Name/Phone Number (for new prescriptions only)	Prescription Numbers (for refills only)
1	○	○	○			
2	○	○	○			
3	○	○	○			
4	○	○	○			

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

DELIVERY SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

○ **Regular** – no charge ○ **Second business day*** ○ **Next business day*** ***Additional costs charged to you**

Delivery Address (If you've chosen Second Business Day or Next Business Day shipping, no P.O. boxes will be accepted)

City | State | Zip Code | Phone Number (– –)

Above delivery address is: ○ For this order only ○ For this and all future orders

All medications in this order will be sent in the same package to the address provided. If a family member's medication should not be shipped in the same package, his or her prescription order should be mailed separately.

PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

Credit card is the only payment option for faxed orders and offers greater member convenience. There is a $20.00 returned check charge. **Do not send cash.** Orders received without payment will delay processing. Any outstanding balances will be the responsibility of the primary insured. If you have questions about your payment amount, call the Prescription Drug Inquiry Unit at **800.423.1973**.

○ **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

○ **Payment by credit card** (Provide information below) ○ MasterCard ○ Visa ○ American Express ○ Discover

Credit Card Number | Expiration Date (MM/YYYY)

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

Yes ○ **No** ○ Please retain this credit card information for my future home delivery purchases.

Credit Card Holder's Signature

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).