## **Christiana Care Mail Order Pharmacy Order Form**

Christiana Care Mail Order Pharmacy 200 Hygeia Drive Newark, DE 19713 Customer Services & Interactive Voice Response: (302) 320-6760 Fax Number: (302) 623-0399

## PLEASE COMPLETE ONE FORM FOR EACH PATIENT

Pati	Patient Name (Last, First, M) Date of Birth			
Mai	ling Address (Street, City, State, Zip)			
	e: PO Boxes and controlled substances require a S	0	-	
**	PLEASE ALLOW 5 TO 7 BUSINESS DAYS FO	<u>OR PRESCRIPTION(S)</u>	<u>TO ARRIVE I</u>	<u>N THE MAIL**</u>
	gits Optum Rx prescription card ID number ation to Member (Self, Spouse, dependent, etc.)			
Prin (Par	ent info for minors) Name		Contact Pl	hone Number
E-m	ail Address:			
List	any drug allergies:			<u>.</u>
	Filling a New Prescription or Refill	Enter Rx# for refill	<u>Circle One</u>	
	Enter Medication Name	Enter Kx# for refin	<b>Process</b> = Fill prescription now <b>Profile</b> = Put prescription on hold to fill at a later date	
1			Process	profile
2			Process	profile
3			Process	profile
	Transferring Prescriptions	Enter Pharmacy Name & Phone	<u>Circle One</u>	
	Enter Rx# & Medication Name	Number	<b>Process</b> = Fill prescription now <b>Profile</b> = Put prescription on hold to fill at a later date	
1			Process	profile
2			Process	profile
3				

• Maintenance medications may be filled twice at a retail pharmacy; the third fill will reject for use of mail order.

Process

profile

• Automatic Refill options are available, contact the Mail Order Pharmacy for details.

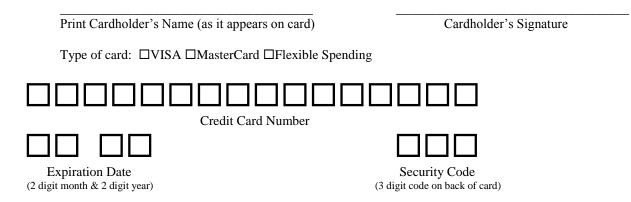
• Contact the Mail Order Pharmacy directly with any changes to your address, contact, or payment info. (Updating info in workday will <u>not</u> update your Mail Order profile)

## **Payment Information**

**Payment must be made in advance of shipping.** You must specify a payment option and provide complete information for that option. Incomplete or expired information may prolong the 5 to 7 day process of your order.

Select a payment option below by checking one of the boxes either "*I am paying by credit or FSA card*" or "*I am paying by payroll deduction*", fill in all required information for your selection.

## $\Box$ I am paying by credit or FSA card.



 $\Box$  I am paying by payroll deduction.

My Employee Identification Number:



I HEREBY AUTHORIZE CHRISTIANA CARE HEALTH SYSTEM TO MAKE PAYROLL DEDUCTIONS OF ALL PURCHASES MADE USING MY IDENTIFICATION BADGE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR AND AGREE TO PAY ALL CHARGES MADE AGAINST MY IDENTIFICATION BADGE. I AGREE NOT TO HOLD CHRISTIANA CARE HEALTH SERVICES RESPONSIBLE FOR ANY DEDUCTIONS FROM MY CHECK CAUSED BY CHARGES WHICH I MAY DISPUTE. I FURTHER UNDERSTAND THAT UPON TERMINATION OF MY EMPLOYMENT ANY REMAINING BALANCE WILL BE DEDUCTED FROM ANY ELIGIBLE PAID LEAVE HOURS OR MY FINAL PAYCHECK, IF APPLICABLE. PLEASE SIGN BELOW IF YOU AGREE TO THE TERMS SPECIFIED HERE.

Employee Signature:	Date:	