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

Patient Name (Last, First, M) ____________________________________ Date of Birth ___________________

Mailing Address (Street, City, State, Zip) ____

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Note: PO Boxes and controlled substances require a Signature at the time of delivery.

****PLEASE ALLOW 5 TO 7 BUSINESS DAYS FOR PRESCRIPTION(S) TO ARRIVE IN THE MAIL****

9 digits Optum Rx prescription card ID number…… ☐☐☐☐☐☐☐☐☐

Relation to Member (Self, Spouse, dependent, etc.) ____

Primary Cardholder____________________________________ ______________________________

(Parent info for minors) Name Contact Phone Number

E-mail Address:____

List any drug allergies:____

	Filling a New Prescription or Refill **Enter Medication Name**	**Enter Rx# for refill**	**Circle One** **Process** = Fill prescription now **Profile** = Put prescription on hold to fill at a later date
1			Process profile
2			Process profile
3			Process profile
	Transferring Prescriptions **Enter Rx# & Medication Name**	**Enter Pharmacy Name & Phone Number**	**Circle One** **Process** = Fill prescription now **Profile** = Put prescription on hold to fill at a later date
1			Process profile
2			Process profile
3			Process profile

- **Maintenance medications may be filled twice at a retail pharmacy; the third fill will reject for use of mail order.**
- **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 not 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.

☐ I am paying by credit or FSA card.

___________________________________ ___________________________________

Print Cardholder's Name (as it appears on card) Cardholder's Signature

Type of card: ☐VISA ☐MasterCard ☐Flexible Spending

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Credit Card Number

☐☐ ☐☐ ☐☐☐

Expiration Date
(2 digit month & 2 digit year)

Security Code
(3 digit code on back of card)

☐ I am paying by payroll deduction.

My Employee Identification Number:

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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: _____________________

Revised 06/2017