

Directions: Please print in **BLUE** or **BLACK** ink, using all **CAPITAL** letters.



Patient Profile and
Prescription Order Form

MEMBER INFORMATION

Male Female

Date of Birth (MM/DD/YYYY)

ID Number (located on card)

Group Number

Email-Address (to receive information regarding the processing of your order)

Phone Number

Last Name

First Name

Physical Address 1

Physical Address 2

City

State

Zip Code

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

PLEASE COMPLETE

ALLERGIES

- Aspirin
- Cephalosporin
- Codeine derivatives
- Morphine derivatives
- Penicillin
- Sulfa drugs
- None known
- Other (use lines below) _____

HEALTH CONDITIONS

- Arthritis
- Asthma
- Diabetes
- Glaucoma
- Heart disease
- Hypertension
- Pregnancy
- Thyroid disease
- None known
- Other (use lines at left) _____

I would prefer my prescription bottles to have easy open caps YES NO

DEPENDENT INFORMATION

Male Female

Date of Birth (MM/DD/YYYY)

Dependent Last Name

Dependent First Name

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

PLEASE COMPLETE

ALLERGIES

- Aspirin
- Cephalosporin
- Codeine derivatives
- Morphine derivatives
- Penicillin
- Sulfa drugs
- None known
- Other (use lines below) _____

HEALTH CONDITIONS

- Arthritis
- Asthma
- Diabetes
- Glaucoma
- Heart disease
- Hypertension
- Pregnancy
- Thyroid disease
- None known
- Other (use lines at left) _____

I would prefer my prescription bottles to have easy open caps YES NO

E-mail Address (to receive information regarding the processing of your order)

MEMBER ALTERNATE SHIPPING INFORMATION

This is alternate shipping information for a member's medication. If a dependent's medication needs to be delivered to a different address, please specify below or contact miRx at 866.894.1496.

This shipment only Temporary address change indicated to the right Start Date End Date

Patient Name

Alternate Mailing Address

City

State

Zip Code

Alternate Phone Number

REFILL INFORMATION

Auto Refill Yes No (If you select autofill, you must contact us with any changes to your prescription.)

To order refills, visit www.ebms.com and click on miRx under "Products and Services," call 866-894-1496, or enter your prescription number(s) here and send in this form (see below):

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

PAYMENT AND SHIPPING INFORMATION

By submitting this form, you hereby authorize release of all information to miRx as required to process your order under your benefit plan. Please enclose your prescription with this form.

Total number of prescriptions this order.....

Total included for copay(s).....\$.

Regular Shipping.....\$ NO CHARGE

Next Business Day (\$19.00).....\$.

2nd Business Day (\$12.00).....\$.

Total Payment Due.....\$.

Price of shipping may change by carrier without notification and may vary depending on weight and zone.

SEND TO:

MAIL: miRx, P.O. Box 21669, Billings, MT 59104;

EMAIL: miRx@ebms.com or

FAX: 1-406-869-6552

Payment Options

Check made payable to miRx

Charge credit card listed below for this order only

Charge credit card listed below for this and all future orders

American Express Visa Discover MasterCard

Credit Card Number

Expiration Date /

PLEASE READ AND SIGN: I certify that the information provided on this form is current; and I authorize miRx Pharmacy to substitute generic drugs in all cases when legally permissible, in accordance with applicable law, consistent with my doctors order.

Member/Cardholder Signature _____

Date _____