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

miRx prescription mail order

Patient Profile and Prescription Order Form

Member Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____

ID Number (located on card) _____

Group Number _____

Last Name _____

First Name _____

Mailing Address _____

Physical Address (If different from Mailing Address) _____

City _____ State _____ Zip Code _____

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

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

Home Phone _____

Work Phone _____

Cell Phone _____

Preferred Method of Communication (if by phone, specify which number): _____

Additional Services Available: ☐ Auto Refill ☐ Text Message (when prescription is complete) ☐ Email Notifications (when prescription is shipped)

Cell Phone Carrier
- ☐ Verizon ☐ AT&T
- ☐ Sprint ☐ T-Mobile
- ☐ Other _____

For text message notification only

Dependent Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____

Dependent Last Name _____

Dependent First Name _____

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

Alternate Phone _____

Cell Phone _____

Additional Services Available: ☐ Auto Refill ☐ Text Message (when prescription is complete) ☐ Email Notifications (when prescription is shipped)

Cell Phone Carrier
- ☐ Verizon ☐ AT&T
- ☐ Sprint ☐ T-Mobile
- ☐ Other _____

For text message notification only

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

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 1-866-894-1496.

☐ 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 _____

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..... _____

☐ Regular Shipping.....$ NO CHARGE
☐ Next Business Day ($19.00).....$ _____ . _____
☐ 2nd Business Day ($12.00).....$ _____ . _____

Total Shipping Cost.....$ _____ . _____

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

SEND TO:
MAIL: miRx, 993 S 24th St., Suite A; Billings, MT 59102;
EMAIL (scan form first): miRx@ebms.com or
PHONE: 1-866-894-1496
FAX: 1-406-869-6552

Payment Options (to pay over the phone, call 1-866-894-1496)

☐ 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

Click Here to Submit!