



MEMBER INFORMATION

Last Name First Name Initial
Cardholder I.D. Number (usually found on your health plan benefit card) Group I.D. Number
Prescription Plan Name

DEPENDENT AND MEDICAL INFORMATION: If any dependent requires different shipping and/or billing information, please fill out additional registration form(s).

Table with 6 columns: Last Name, First Name, Middle Initial, Date of Birth, Sex, Allergies. Rows for Member, Spouse, and three Dependents.

SHIPPING INFORMATION: (All Orders will be shipped to this address unless otherwise notified.)

Street Address Apt.
City State Zip
Home Phone Number (Include Area Code) Work Phone Number (Include Area Code)
Email Address

PAYMENT INFORMATION (Payment required prior to shipping order.)

American Express VISA MasterCard Discover Card
Credit Card Number
CID # (3-4 numbers) Exp. Date (mm/yy)

CID # LOCATIONS:
VISA, MasterCard and Discover:
Back of the card: if present, 3 digits in the signature area to the right of the credit card number.
American Express:
Front of the card: 4 digits on the right above the card number.

May we use the specified card for future orders/unpaid balances? Yes No

SIGNATURE DATE

- I approve generic substitutions when available and permitted by my physician
I do not approve of generic substitutions and request brand only on the prescriptions enclosed. I understand that a higher copayment may apply.

By signing below, I certify that the information provided on this form is correct for myself and all members contained on my health plan policy. I understand that generic medications will be dispensed in all cases where medically appropriate and legally permissible, unless I have stated otherwise above. I further understand that my physician may be contacted about a possible cost-saving medication that is on my health plan's formulary when medically appropriate and legally permissible. After you have read and completed the section above, please sign and date.

SIGNATURE DATE

PLEASE PLACE COMPLETED APPLICATION, PRESCRIPTION(S) AND PAYMENT INTO POSTAGE-PAID ENVELOPE.
If you have any questions, please contact SaveDirectRx at (888) 637-5121

